Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month -20/M Arthur M. Knight 201 ∖∧ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death -anKlin Hosbita timbre nare Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours 01/28/1927 Maryland Director 83 212-20-5256 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1015 Middle River Road 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No Specify: Completed Specify: 3 Widowed 4 Divorced Year or Dates. WW II White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Self-Employed Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur K. Knight Anna Messenger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin L. Knight (son) 4026 Briar Point Road - Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns. 06/03/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) of Standard of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ -onaest disease or condition resulting in death) Medical Due to br as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Unknow signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by umonar 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has bal director, page 2 sl autopsy performed death? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ၉ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on re and title of certifier 29b. Signatu 29d, Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Date filed

9000 Frank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Month Physician/ 12:30 p Karner J. Agnes May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson <u>Stella Maris</u> 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year Months 1 🗆 M 2 🔀 F New York Director 064-18-9110 March 85 Usual Residence of Decedent than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Reisterstown MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Completed by Funeral U.S.A. 21136 340 Leyton Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 21215-0036 1 Yes 2 X No Specify White 3 ☑ Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Indicate the strong of Health and Mental Hygiene. Important: If item 27 is marked other through injury or other through any injury or other th Elementary/Seconday (0-12) College (1-4 or 5+) Factory Line Operator 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Agnes Issowitz Franke1 George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 Reisterstown Maryland 340 Leyton Road Ronald A. Karner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 Cremation 3 Removal from State Owings Mills, MD Garrison Forest Vet. 6/7/10 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road dry le Eline Funeral Home 21136 Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovasc Ular Pnysician, fther lot least disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Inneral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Was case referred to medical examiner? Other: 2-No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records,

2010

KARNER

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifie

CRNP GENNIFER HAUF, 31. Date filed (Month, Day, Year)

23;; DULANEY VALLEY ROAD **R**gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🖵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	State of Maryland / Department of Health and M Certificate of Death	Reg. No.	010 17003
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/Medica	Ab City Town or I	ocation of Death 4c. C	2010 0130
Examine	GLADE VALLEY NSG & REHAB WALKER		FREDERICK
Funeral Director	5. Social Security Number 6. Sex 1 D M 20 F 7. Age (In yrs. lest birthdey) 1 H Under 1 Year 1 H Under 24 Hrs. Months Days Hours Min. Usuel Residence of Decedent	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
No.	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Ba-1 st	MD FREDERICK FREDERICK		1 X Yes 2 □ No
with the	106. Street end Number 10f. Zip Code 21 7 0 1		en of What Country? JSA
death	2() 4 MILL RACE ROAD 11. Maritel Stetus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Speriments) If Yes, specify Cuban, Mexican, Puerto		I. Race - American Indian,
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yland 21215-01 uld be filed within 72 hot Mantel Hygiane. riked other than "nature site event, the Hedical F	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of work) (if DO NOT use retired)	ing 16b. Kind	d of Business/Industry
212: I withir iane.	Elementery/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) TEACHER	EDI	CATION
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Transfer tra	19a. Informant's Name/Relationship (Type, Print) NORMAN KOON TZ / SPOUSE 2614 MILL RACE R		RICK, MD 21701
Saltimore, semit. Pages 1 an appartment of Heal appartment of Heal appartment. If Item 2 any Injury or other ance.	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c Loca	ation - City or Town, State
Page mant of ant: If ury or	4 Donation 5 Other (Specify) STATE ANATOMY BOARD	5/26/10	
Balt Depart Import Import Pinger	21. Signature of Funeral Service Licensee Ronald S. Wade Director 22. Name and Address of Facility State Anatomy Boar Baltimore, Marylan		altimore Street
	23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.		Approximate Interval Between
Physician /Medical	F J Ch. C.	at to	Onset and Death
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be sit	PNEU MONIA		3 Days
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is, F.C. BOX of that the death certigened by the attending be detached for use a by Physician/M.	CORONARY ARTERY DITEACE	1 Yes 2□	No 3 Probably 4 Unknown
II RECOIDS, P.O. BOX (The law requires that the death certificate has been signed by the attending pege 2 should be datached for use a Completed by Physician/M.		24a. Was an autops performed?	available prior to completion of cause
ne law he law a has l		1 Yes 2	of déath? No 1 ☐ Yes 2 ☐ No
VITALI clan: T clan: T entificet ector, pe	25. Was case referred to medical 26. Place of Death	(Check only one)	12703 22110
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ding P h. After t funera	1 Maturel 5 □ Pending (Month, Dey Year) Injury Work?	28d. Describe how injury	occurred
DIVISION OF the or Attending Phy rs after death. al Director: After this led in by the funeral of	2 Accident	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
_ <u>assag</u> O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, a		
the Hospi nin 24 hou the Funer npletaly fill	(Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred end menner stated.	ed at the time, date and p	place, and due to the cause(s)
To the with To the com	29b. Signature and title of certifier A D 21 9 4 4	S	signed (Month, Day, Yeer)
	30. Name end address of person who completed cause of death (Item 23e) (Type, Print)		21702
	30. Name end address of person who completed cause of death (Item 23e) (Type, Print) TRMS SCON LATE TONGY AVE 31. Date filed (Month, Day, Yeer) 32. Registrer's Signature for Aparts JUN 0 2 2010	TOITE 204	FIEDBRICK, MD
State Registrar	St. Date med (mornin, Day, reer)		
	JUN V CUIV		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Month Antonios holivas 4 : 55 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center N/A altimore 8. Date of Birth (Month, Day, Year JAN 5 , 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 1 M 2 DXF 64 Months Days Hours Min. 213-88-4834 Director Yrs 1946 GREECE Usual Residence of Decedent or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. BALTIMORE EASTWOOD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
UNITED STATES 23a Funeral 21224 7179 EASTBROOK AVE. or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 WHITE "natural", 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify. Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be flied within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megones. Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION MASON Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SOFIA DARAKAKIS MICHAEL KOLIVAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7179 EASTBROOK AVE., BALTIMORE, MARYLAND 21224 MORPHINI KOLIVAS/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 05/28/2010 BALTIMORE, MARYLAND OAK LAWN CEMETERY Signatu of Funeral ervice Licenses 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock heart fallure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death **C**hysician/ disease or condition resulting in death) Cerebellar Hematoma Medical Examiner Disseminated Intravascular Coaquiation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Yes 2 🗆 No ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ bacteremia Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2: No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) leena Backhus, 1336374321 3010 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Geene Street, Baltimore, MD,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend #30 per DVR g904 6/2/10 TT

State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30^{Day} MAY KAPLAN SEMARIY 2010 10:04 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 16 OLD COURT ROAD, APT. BALTIMORE BALTIMORE 9. Birthplace (State or Foreign Country) RUSSIA Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □**X**M 2 □ F Months Days Hours Min. 218-37-2508 1270271930 79 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director MD BALTIMORE 1 Tes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral RUSSIA 16 OLD COURT ROAD, APT. 201 21208 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Specify: traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEER MECHANICAL ENGINEERING is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 EMMANUEL KAPLAN LYUBOV UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau SVETLANA KAPLAN/WIFE 16 OLD COURT ROAD, APT. 201, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMORE HEBREW CEM. 5/31/2010 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death Immediate Cause (Final NSON Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions if any leading to immediate Physician/Medical Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy Live Birth 2 L retardoa.
Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accider injury 5 Pending 2 Accident 3 Suicide 1 Ves 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a To the Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number D 0054746 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6821 Reisterstown Road # 206 Baltimore MD 21215 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 31ay 2010 Timothy Patrick Lyons 10:42 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore <u>Gilchrist Hospice Center</u> Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 🗆 F Months Days Hours (Month, Day, Year 04-24-1922 Director 185-12-0563 88 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 □ No Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21214 5211 Walther Avenue hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ፩ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: WII Specify: Completed 3 Divorced 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Baltimore City permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Firefiahter Fire Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elise B. Houlihan John Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21214 Irene Lyons - Wife 5211 Walther Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corporation 06-02-2010 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature Jouneral Service Incensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart valiure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Enysician MPUCATIONS OF DAUS Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner 3 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours affer death.
24 hours affer death.
Purparal Director: After this certificate has been signed by the attending physician and eled filled in by the furnerial director, page 2 should be detached for use as the burial-transit eled filled in by the furnerial director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. 23e. Did tobacco use contribute to the cause of death? Be Completed by ADVANCED DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? ARTERY CORONARU 24a, Was an performed? 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗌 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident 5 Pending iniun MAY 23, 2010 KNENDWIM 1 Tes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

SDI WALTHER AVENUE, BALT MARE, I determined AT HOME Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 164395 MAN 31, 2010

State

Registrar

DANIEUE DOBERMAN, MY 6701 N CHAPLES ST, SUITE 4105 BALTIMORE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of I	Maryland / Dep Ce	artment of F rtificate of L		Reg	ene 0 0 17007
Physic /Medi	cal	Decedent's Name (First, Middle Per U) 4a. Facility Name (If not institution		L	ittle	al anation of Double	2. Date of Death	28 20/0 9 13A M
Exami	ner	The Johns Hopkins	_		Baltimore	City	•	4c. County of Death
Funeral Director		5. Social Security Number 455-68-0732		Age (In yrs. last birthday, 65 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Aug 04	9. Birthplace (State or Foreign Country) 1, 1944 Texas
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
e Mary 3a-f sh iffed a	ctor	MD Hov	ward	Columb	ia			1 ∑Ves 2 □ No
with the	Director	10e. Street and Number	-t Ct		10f. Zip-Code	4	10g	. Citizen of What Country?
death	Funeral	10335 Nightmi	12. Was Decede	nt Ever in U.S. 13.	Was Decedent of H	Ispanic Origin? (Spe	ecify Yes or No-	United States 14. Race - American Indian,
15-0036 172 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Mari	If Yes Give	No	If Yes, specify Cuba 1 ☐ Yes 2 🖳 No	Specify:	Hican, etc.)	Black, White, etc. Specify: White
215-0036 thin 72 hours aft e. an "natural", or Medical Examir		15. Deceder	it's Education st grade completed)	16a. Dece	edent's Usual Occup	eation	ing 16	b. Kind of Business/Industry
121 within	Completed	Elementary/Secondary (0-12)	College (1-4 c	or 5+) life.	DO NOT use retired acher	daming mode of women	9	Private Sector
nd 21.	Be Co	17. Father's Name (First, Middle,	Last)	. 10	acher	18. Mother's Nam	e (First, Middle, Ma	
Maryland d 2 should be file th and Mental Hy is marked oth traumatic event	To E	Unk Goodnigh		· T			Deckard	
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		19a. Informant's Name/Relations Donna Hawk /			ing Address <i>(Street</i> .36 Gatsby		·	Dity or Town, State, Zip Code) MD 21045
es 1 ar of Hea f item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removel from State	20b. Place of Disp	osition (Name of matory or other place	ee)	Date 200	c. Location - City or Town, State
altimore, mit. Pages 1 a partment of Her portant: If item y injury or othe		4 Donation 5 Other (S	pecify)	Chesape	ake Crema	atory	2010	Beltsville, Maryland
Dal permi Depa Impo any ir		21. Signature of Funeral Service	Ritt Mo	1443	2. Na cred Addie 8717 Gre			rnatives owson Maryland 21286
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the death. Do not en line.				Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Min		dystun	ction		Onset and Death
Examiner			Due to (or a	as a consequence of):	lure			4
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Box death ce attendir	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth	2 Fetal death 3 at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	у		23d. Date of delivery Month Day Year
at the by the etache	Phys	9 Unknown Part II. Other significant condition	9 Unknown	-	underlying eques of	uon in Dest I	One Did to be a	and the same of death 0
COrds, P.O. BOX 6 v requires that the death certifi been signed by the attending I should be detached for use a	d by	rattii. Other significant conduct	ms contributing to death	r but not resulting in the	undenying cause gi	venin Parti.	23e. Did tobac	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
2 s b	Completed						24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The ate has page	Com						_ performed	d? death? No 1 ☐ Yes 2 ☐ No
VITAL Sician: Th certificate director, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpa	itient 2 🗆 ER/Outpatier	nt 3 DOA Othe	26. Place of Death		e 6 ☐ Other (Specify)
n of ng Physter this ineral d	on: To	27. Manner of Death 1 Natural 5 Pendin	28a. Date of In	jury 28b. Time o		y at	28d. Describe how	
OIVISION or Attending after death. Director: After in by the fune	licati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could i	gation not be 28e. Place of i	njury - At home, farm, str		Yes 2 No	28f Location (Stree	et and Number or Rural Route Number,
al or A safter s after all Direct bed in b	Certification:	4 Homicide determ	building,	etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, St	
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical (of examination and/or in				se(s) and manner as stated. e and place, and due to the cause(s)
To the within To the comple	Mec	29b. Signature and title of confier	And mainter		29c. License	number	29d.	Date signed (Month, Day, Year)
		1 7,6	hler	Dos	Re	1000		May 28,2010
8x1		30. Name and address of person	7/ // 2	f death (Item 23a) (Type,	Print)	600 N	North Wolfe	St, Baltimore, MD, 21287
Sta Registr		31. Date filed (Month, Day, Year) JUN 0 2 201	32. Regis	trar's Signature	1			
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alice Marilyn Lounsbury Month 20:0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SALTIMORE ANNE AGHINCITON MEDICAL CA **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 084-16-1872 1 □ M 2 🛣 F 87 Country) 2/18/1923 Director Yrs. NY Usual Residence of Decedent or 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Hanover 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Funeral 7548 Old Telegraph Road items 23a 21076 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 → Widowed 4 □ Divorced Specify: White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working other than Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 Harry Deplidge Vinabelle Vicary 19a. Informant's Name/Relationship (Type, Print)
Carolyn Lardeo / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7804 Chevalier Ct., Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crem: 6/2/2010 Woodbine, MD Signature of Funeral Service License Lorpta Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Onset and Death HIZONIC Physician/ OBSTRUCTIVE disease or condition resulting in death) TUMONAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions. cause. Enter Underlying Cause Olisease or iinjury Due to (or as a consequence oi). Exami burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 4 Pregnant
9 Unknown Pregnant at time of death Month signed by the a Dav Year 9 Unknown P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? Records, Completed certificate has been si irector, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No Division of Vital filled n by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ Other 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; After 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes within 24 hours after death. To the Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Prin and address of person who comp Glen Burne 31. Date filed (Month, Day, State 32. Registra

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ Hector Α. Landaeta 2010 3:20 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2929 Baltimore Avenue Halethorpe **Baltimore** Social Security Number Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year JAN 30, 1 Months Days Hours Min 216-54-5500 Director JAN Venezuela Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Tes 2 XNo MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2929 Baltimore Avenue 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes 2 □ No Specify: Venezuelan Maryland 21215-0036 If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter t. Page 1 and 2 should be filed witternent of Health and Mental Hygientant: If item 27 is marked other 1 jury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ IInk. Unk. Landaeta Cecilia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2929 Baltimore Avenue Halethorpe, MD Marjorie J. Landaeta, wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department or Important: If any injury or 4 Donation 5 Other (Specify) Metro Crematory, Inc. 5/29/10 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (Trysician) MONTHS metastat 10 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by pe No 3 Probably 4 Unknown 1 Yes funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 M No Other: 1 Tyes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes Investigation Accident 24 hours after death Funeral Director: the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check within 2 To the 3 only one) D35 25 May 29, 2010 of death (Item 23a) (Type, Print) dress of person who completed cause BALTIMORE CaroleB Miller 900 MO C 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 2010 2:35 РМ Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner Golden Living Center Westminster Carrol1 Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Year 19<u>24</u> 1 🗆 M 2 🗓 F Months JAN 24 Virginia 579-28-7125 86 Director Usual Residence of Decedent 10a State notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Carrol1 Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 1234 Washington Road 21157 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Floral Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H ၉ McGi 11 Whalen Florence Mildred Sisson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health John Russell Laughlin, son 891 Gettysburg Road Littlestown, PA 17340 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 05/31/10 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final O set and Death Physician/ Beun disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner encer-ewe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): led by the attending physician and detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Berrentu 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page certificate I 1 Yes 2 No 1 ☐ Yes 2 🔼 N Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending injury work? 1 ☐ Yes 2 ☐ No Netural Accident Investigation To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the base of examination and/3 Certifying Nurse Practions: To the best of my knowledge. 29a. Certifier leath occured at the time, date and place, and due to the cause(s) and manner as stated. stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the best of my kn ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie n37949 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First Middle Last 2. Date of Death Physician/ 29 Day May 2010 7:30 P M Gilbert Joseph Milan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Victorian Estates Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🕱 M 2 🗆 F Months Hours Min. Mar 4, Day, Year) Maryland **Director** 69 217-38-6415 Usual Residence of Decedent i Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 144 N. Hickory Avenue 21014 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>5+</u> Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of Joseph Phyllis Kleinota 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st of Health a fitem 27 i Charles Joseph Glebas/Executor 2914 87th Avenue E Parrish, Florida 34219 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of I Page 1 1 Burial 2 Cremation 3 Removal from State any injury or Final Journey Crematory 6/1/2010 Woodbine, Maryland Ponation 5 Other (Specify) Sign ure of Funeral Service His Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M uanita M00957 MD 21029 Momay Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metabolic Encephalopathy Medical Due to (or as a consequence of Examiner Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) and I-transit Exami that the death certificate be executed Severe Malnutrition Due to (or as a consequence of) burialphysician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Pregnant at time of death 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Advanced Dementia 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 N 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Assisted-Living Hospital Other: 1 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending work? 1 ☐ Yes nours after death.

neral Director: Aft
dilled in by the fur Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nuyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056607 May 30, 2010

Registrar

State

68760

Box

P.O.

Vital

Division of

Suite D, 208 Plumtree Road

32. Registrar's Signature

Bel Air, Maryland 21015

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Angelo, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 29 20 10 11:16PM Doris Ruth Miller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death (arrol) mn est minster 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. (Month, Day, Year) 218-26-8420 Director 82 MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1883 Deer Park Rd. 21048 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Clothing Westminster Knit Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lewis Andrew Myers Edna B. Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Jean Miller-daughter 109 Marydell Dr., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Deer Park Cem. 1 Burial 2 Cremation 3 Removal from State 6/2/2010 Finksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licensee 254 E. Main St., Westminster, MD 0. thomas 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events Examiner signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical ivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year ☐ Pregnant at time of death ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) One Hous ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 \square No ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 006458 person who completed cause of death (Item 23a) (Type, Print) uth Center Street

DHMH 17 Rev 7/2009

Registrar

10-04116 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alvin Basil Martin, III State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day May 30, 2010 Medical Examiner 1137 hrs 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number University Hospital Baltimore 5. Social Security Numbe If Under 1 Year 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY **Funeral** Director Months Days Hours Min 1 M Country) Usual Residence of Decedent 10a State 10b. Count Town or Location 10d. Inside City Limits 1 Yes 2 No or 28a-f shov tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, <u>the Medical Examiner must be notified at once.</u> Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black "natural", or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Yes 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year þ Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last own, State, Zip Code) tant: If item 27 is or other traumat 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: 22. Name and Address of Facility nter the disease, or complications that caused the death. Do not enter the ode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failuré. List only one cause on each line Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pur Physician/Medical physician a AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, taal or Attending Physician: The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d, Date of delivery Live birth 3 Ectopic pregnancy Day Fetal death Month Year for use as past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? 1 🗸 Yes this certificate director, page ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 / Inpatient 2 Other₄ ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: May 30, 2010 Subject shot Natural 1059 hrs 1 Yes 2 ✔ No death. Director: d in by the f Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 2111 Ramsey Street, Baltimore, Md determined Funeral (Specify) Townhouse / Rowhouse Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical To the F 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State Registra

Jack Titus MD

30. Name and address of persor

32. Registrar's Signature

completed cause of death (Item 23a)

Deputy Chief Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 31, 2010

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 Physician/ Arlene Minutelli Reta 6:00 P M May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7801 Pennisula Expressway Apt. Dundalk Baltimore Co. 8. Date of Birth
(Month, Day, Year)
6 • 1928 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 220-24-2427 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Dunda1k MD Baltimore 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 7801 Pennisula Expressway Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 72 hours after ģ Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates. traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 12 Years 2 Years Union Memorial Hosp. Property Account Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stella M. Stair Charles S. Balliet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 1747 Stokesley Road Dundalk, Maryland 21222 (Daughter) Lynn Sperry Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns. 5/24/2010 Baltimore, Maryland 4 Donation 5 Other (Speoff) 21. Signature of Pur al Servio 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. <u> 7922 Wise Ave.</u> Dundalk, Maryland Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CANCER Physician, COLON Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or linjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24/16 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Mohammad Taqi 23 Shipping Place Dun Dundalk, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Physician/ Miller, Jr. 2010 John Beverly 03:15 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death SAINT JOSEPH MEDICAL CENTER OWSON BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Months Days Hours Min. Country) Maryland Director 1944 213-46-1963 Usual Residence of Decedent 10a. State 10b. County at 10c. City. Town or Location 10d Inside City Limits Director or 28a-f sl notified 1 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? "natural", or items 23a o Funeral within 72 hours after death with 6302 Bellona Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced White Completed Year or Dates. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene tant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Driver Transport Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Beverly Miller, Sr Elizabeth Douglas 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Koziol /Daughter Murdock Road, Baltimore, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2010 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Sigrature of Funeral Service Licensee 22. Narce and the sent Family Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RACEREBRAL Immediate Cause (Final Chysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): RENAL DUEME Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P. Completed by ENCEPHALOPATH 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? After this certificate 2 No 1 🗌 Yes (Ospne... 24 hours after deau... • Funeral Director: After this ce.... - in by the funeral director, pa Yes 2 of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work Division 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2. Certifying Nurse Prantianen To the Sest of my knowledge Name and address of person who completed cause of death (item 23a) (Type, Print) 0 -DD M-D31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0919AM NIGHIA MURIEL 2010 Medical MEDICAL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAYVIEWCENTER BALTIMORE JOHNS HOPKING Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day,) 07 24 Months Days Hours Min. Year) 1 🗆 M 2 💢 🕏 26 Director 061-68-4173 NV Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d Inside City Limits filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD Baltimore Cockeysville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 Lake Vista Circle 21030 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify Specify: 3 Widowed 4 Divorced Black Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Manor Care Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Housekeeping Nursina Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marvin Tate Carmen Muriel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derod Muriel-Brother Lake Vista Circle, Cockeysville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 6/4/2010 Woodlawn, Md 21. Signature of Funeral Service Lice see 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, 21215 Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and D ath shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NEUMONIA WEEKS Se wentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying YEARS RENAL FAILURE attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed after death.

Director: After this certificate f 1 Yes 2 No Yes 2 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: Certificate: To 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D32079 vantz MAY 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Ave Baltimore MD Adam Hernandez MD 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

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amend item 23e per doc 9904 6-9-10 lytem State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 11:458 CATHERINE C. 29^{ay} 2010^{au} MELZER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4309 ANNTANA AVENUE RASPEBURG BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Rirth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 Months Days Hours 0872671928 Director 218 22 5971 81 MARYLAND Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE RASPEBERG 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4309 ANNTANA AVENUE 21206 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) HOSPITAL O` DIETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JAMES** CLARKE CONSTANCE MARIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN E. VANCE / DAUGHTER 215th STREET PASADENA, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/02/10 METRO CREMATORY BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature. vice Licensee 1211 CHESACO AVE BALTO., MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Inijury that initiated events Examiner Due to (or as a consequence of): burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 🗗 Frobably 4 ☐ Unknown s been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work s after death.

I Director: Aft
od in by the fur 2 ☐ Accident 3 ☐ Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in I within 24 hours a

To the Funeral D

completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign truce and title of certifier 29d. Date signed (Month, Day, Year) MD 6/1/2010 D40854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultinon St Paul 227 21202 1213 85855 2016 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26^{Day} 201^Y0 Physician/ May 6:14P.M Andrew Henry Mantik Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 924 South Belnord Avenue Baltimore City 6. Sex 1X M 2 F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours Now26, 1921 Maryland 218-10-8158 88 Director Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 924 South Belnord Avenue 21224 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Seconday (0-12)}}{10\text{ th}}$ College (1-4 or 5+) Machinist National Gypsum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٩ Frank Mantyk Stella Wozniak 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 South Belnord Avenue Baltimore, Md21224 Mantik-Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jun ete 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus Cemi 1, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raczorowski Funeral Home, FA Signature of Funeral Service Licensee once. 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner years Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

the of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 1 ∐ Yes 2 L g ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Courdio my opath Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 N To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 XNo 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier (Check Signature and titl 29d. Date signed (Month, Day, Year) May 28, 2010 who completed cause of death (Item 23a) (Type, Print) New land PAUL Schwartz MD 3572 31. Date filed (Month, Day, Year) 32. Redstvar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year ELIZABETTI MAY 26 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F 213-32-2598 Director JAN 26. 1935 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm M. dical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1XYes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6532 Belle Vista Avenue 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ģ Specify: 3 ☐ Widowed 4 🎇 Divorced White Completed 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerk Insurance Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Novotny Marie ဂ္ Gruss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn M. Murphy, daughter 6351 Loring Drive Columbia, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any Injury or otl
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 05/28/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 OMIN /Medical Due to (or as a consequence of): Examiner Squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Cheoric signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atter this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 No 1 ☐ Yes 2/2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ A/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) D00 65854 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard County General Hospital Columbia, MD 21044 gistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mille Physician/ Medical Town, or Location of Death **Examiner** IMOU 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months Director or 28a-f show 10a. State 10b. County City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗆 🌠 2 🗆 No more 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a cedent Ever in Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Armed Forces?

1 Yes 2 No
f Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 hours after should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 ☑ No Specify. 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) injury or other traumatic event, Be (First, Middle, Last) မ permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2 Cremation 3 Removal from Donation 5 Other (Spec Signature Funeral Ser 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final h sician/ TROKES disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 No 1 Tyes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No HOSPICE-은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) MAY 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUS-DOBERMAN, MO ST. 8UITE-4105 BALTIMORE, MA 21204 31. Date filed (Month, Day, Year) State JUN 0 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MA Year **Physician** 11:15 AM 26 Jesse Muffoletto /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMOVE HOSPITA nas If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/20/1923 5. Social Security Number **Funeral** Months Days Hours **1** M 2 □ F 215-14-9284 Yrs. Maryland 87 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mardal Hygene.

The state of Health and Mardal Hygene.

The state of the state o 1 ☐ Yes 2 ☐ No Director Maryland Carroll Manchester 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 2302 Bachman Valley Road 21102 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White þ 3√ Widowed 4 Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rody & Fender Mechanic Automobile Repair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Muffoletto Phillie Cerito ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Muffoletto / Son 2302 Bachman Valley Road Manchester, Maryland 21102 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page
Department of
Important: If
any injury or
once. New Cathedrak Cemetery 06/02/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes PA 5311 Fdmondson Avenue Baltimore, Maryland 21229 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the diseas shock, or heart failure of the only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Osca Head week /Medical Due to (or as a consequence of) **Examiner** SUBARACHNOIN Six menticity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Acinosis bouzl CACTLL burial-tra Due to (or as a consequence of): P.O. Box 68760 attending physician Hypstension Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pi Month Year in the past 12 months? 5 Other (spe ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Atterding Physician; The law autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1₫ Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Division of Certification: To After this 28b. Time of Injury A 27. Manner of Death . Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 🗌 Natural 5 Pending 21-2010 1 ☐ Yes 2 🗖 🕶 Fell 2 Accident 3 Suicide investigation uh Ject 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 50Me BACHMAN VALLEY POAG 2302 24 hours Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Implementation on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 50293 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Agnel Hospital, BACTIMALE

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month.

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Ow service

32. Registrar's Signature

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anatoliu Month MAY Milkis 2010 12:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SEASONS HOSPICE@NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** UKRAINE 1**X**X M 2 □ F Months Davs Hours Min 65 217-37-0392 05/10/9/1945 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5906 PARK HEIGHTS AVENUE, #512 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🂢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify. 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 TAXI DRIVER LIVERY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SHAYA MILKIS MAYTA **BOYMER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMARA MILKIS/WIFE 5906 PARK HEIGHTS AVENUE,#512 BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 05/30/2010 DWINGS MILLS, MD Donation 5 Other (Specify) 21. Sign ure f Funeral Service Licens 22. Name and Address of FacilitySOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ptrysician/ disease or condition resulting in death) Colon Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying signed by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown g 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completed filled in by the funeral director, page 2 autopsy performed? Yes 2 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No Other: - purent hospile မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other Sp 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? injury 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physīcian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number DO057465 Suite 235 - Baltinor, MD. 21709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith 31. Date filed (Month, Da 32. Registrar's Signature State barker Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ から Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 111 Sunset Drive Anne Arundel Annapolis 8. Date of Birth Mar • 16, 1962 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 1 M 2 □ F **Funeral** Days Months Min. Hours NewYork 215-88-6020 48 **Director** Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 Yes 2 No Anne Arundel Annapolis MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 21403 111 Sunset Drive filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XXNo Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) å Marine Transport Owner / Operator 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H
fitem 27 is marked ot
r other traumatic ever Katherine Anne Devine should be John W. Meyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 961 Placid Court, Arnold, Maryland 21012 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kathleen Anne Egloff (sister) Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date May 1 Burial 2 XX Cremation 3 Removal from State cemetery, crematory or other place) 25, 2010 Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) ture of une al Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a con legul nce of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Box 68760 use as IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2☐ Fetal death 3☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 6 Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signatu

and title of certific

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's Signature

31. Date filed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** E ass Ilver Monteamery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) いみがみ。 ひて 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 578-36-650 1 XM 2 - F Yrs. Director 23a or 28a-f show 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director Wont ilve 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 909 Funeral 20902 or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 13Luck "natural", 3 Widowed 4 Divorced Year or Dates. WK. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit, Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me. Elementary/Seconday (0-12) College (1-4 or 5+) 1271+ Be 17. Father's Name (First, Middle, Last) AMBIOSE Neville မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , WASH. DC. 20020 3021 PARK DR. REGINA OWENS 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State andover, MI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Henry LUNRICH JUMAR WASH DC, ZOOVE 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 N 1 Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number RSM MD 00065485 2010 30. Name and address of person who comple ted cause of death (Item 23a) (Type-Print) Panicit 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Albert Nistico Sr. Month Year 29 2010 May 3:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7222 River Drive Road Edgemere Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Hours 76 February **Director** Yrs 197,1934 040~ 26-0597 Connecticut Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10a. State Director 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 Yes 2 No Edgemere death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 7222 River Drive Road 21219 USA 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian. 1 Never Married 2 X Married Black, White, etc. ō ρ Baltimore, Maryland 21215-0036 filed within 72 hours after Specify: White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the once. 12 years Millwright General Motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Nistico Carmela Aruta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgeen Nistico wife 7222 River Drive Road, Edgemere, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Dundalk, Maryland 2010 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundlak, Md. Signature of Funeral Service Licenses Dundlak, Md. 21222 23a. Part 1. Enter the diseased complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph_sician/ DEBILITY disease or condition resulting in death) 3_m Medical Due to (or as a consequence of): Examiner DEMENTIA 2 YRS Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Cause (Disease or iinjury STROKE 9 YRS that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Unknown þ Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed و ک Hypertension / Diabetes 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy performed? prior to completion of cause of death? 1 L Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

eral Director; After this certificate if filled in by the funeral director, page within 24 hours a

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

JENN, FER

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5505

Registrar's Signatu

HOPKINS

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

BAYVIEW CIRCLE, BALTIMORE

29d, Date signed (Month, Day, Year)

29c. License number

062032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 0 | 7028 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Ce	ertifica	ate of	Death					Reg. No) .			
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edical Exami		William Niemi	iemiller Month Day May 13, 2010						Yea	ar	0203 hrs	í				
			not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death													
		Sinai Hospital					Baltimore	•								
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	last birt	hday)	If Under 1 \	rear	If Under	24Hrs.	8. Date of E	Birth(MN	VDD/YYYY	9. Birl	thplace (State o	or .
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othe	ပိ	17. Father's Name (First, Middle	, Last)					18.1	Mother's	Name (F	First, Middle	, Maide	Surname))		
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	William John	Niemiller	:					Edn	а Ма	e Dav	is				
21 ould is mai	ျ	19a. Informant's Name/Relations	ship (Type, Print)		19t	o. Mailing	Address (S	treet ar	nd Numb	er or Ru	ral Route No	umber, (City or Tow	n, State	Zip Code)	
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e, e		20a. Method of Disposition				of Disposit	ion (Name of				Date				Town, State	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she is rother traumatic event, the Medical Examiner must be notified at once.			n 3 Removal f		cremati	ory or othe	er place)									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner m		4 Donation 5 X Other S 21. Signal are of Function Service	Licensee -	ite		22 Na	me and Addr	oss of	Facility							
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	xar	events resulting in death) Last	Due to (or as	a consequence	of):								-			
cuted			d												<u> </u>	
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760, ficate be g physical the burn	Æ	IF FEMALE:		outcome of pre								23	d. Date of			
687 ertifi ding e as t		23b. Was decedent pregnant in the past 12 months?	I I LIVE		1 41		Il death	3 <u> </u> E	Ectopic p	pregnanc	У		Month	D	ay Ye	ear
Box 68 e death certif the attending ed for use as	Sic	1 Yes 2 No 9 Un	known	nant at time of o	neath 5	Othe	er (Specify)					- 1				
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O. that I detac	ě	chronic obstructive p			resulting	j iii tile tili	derlying caus	se givei	iiiiirait	. 1.	1 V Y	_		_	ably 4 Uni	
S, F uires n sign	- Pa	chronic obstructive p	ulfiloriary disea	156		-	_									
v req	Set											psy	l p		topsy findings a ompletion of car	
ecc he lay tte ha	Completed										perf 1 ✓ Yes	ormed?		eath?	s 2	No
Division of Vital Records, P.O. Box 68: rate or Attending Physician: The law requires that the death certifi is after death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be denoched for use as		25. Was case referred to medica	al .				26.Pl	ace of I	Death (C	heck on						
Vita hysicia this cer	o Be	examiner?	Hospital: 1	Inpatient 2	ER/O	utpatient					Home 5	Resid	ence 6	Other		
n of V	⊢	1 Yes 2 No 27. Manner of Death	28a Date	of Injury		Time of Inj		njury at	t Work?		8d. Describe			ed .		
th. Af	틸	1 Natural 5 Pen		h, Day,Year)			1	Yes	2 🔲 N	10						
isior Attend r death rector: by the:	g		stigation 28e Plac	ce of Injury - At	home fa	rm street	factory offic	e build	lina etc	21	Bf Location	(Street	and Numbe	er or Rui	al Route Numb	ner City
Divi	Certification:	dete	Id not be Specify,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,, ,		g, oto.		or Town,				an iteato itanio	or, o.t.y
ospit hour y fill		29a. Certifier	(der de		d at the time	4.4.			1.11.			11		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - trans	Medical	(Check only Certifying P	hysician: To the be miner:On the basis	-	_											
To t To t	Jed	29b. Signature and title of certific	and manner:		1 21	01	29c. Lice								th, Day, Year)	
		290, Signature and title of Certific	7/14-6	7/.///	190	580									III, Day, real)	
		Ouco.	Valle-	jeed				C.M.E				ivia	y 13, 20	10		
		30. Name and address of person				44.5	0:	_			100:					
		Victor Weedn MD JD	Assistant Me				nn Street	, Balti	imore,	MD 2	1201					
	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ture	1	wed									
Regist	rar		2 2010 x	Jones	A.	406	W.									
		₩ ₩ 11 W	/													

ORIGINAL

OCME

10-03819	
Kevin Owens	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kevin Owens		1- For State Registrar			tment of ficate of	Health and Me Death	ntal Hygiene	Reg. N	20	0 1702
Physicia Medical Exami		Decedent's Name (First, Mi Kevin Owen	· ·				2. Date of Month	Da		3. Time of Death 0120 hrs
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death								
		St. Agnes Hospital				Baltimore			N/A	
Funeral Director		5. Social Security Number N/A	1 M 2 F	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year If Under 1 Yea			M/DD/YYYY) 9. B Fore	
any		Usual Residence of Decedent 10a. State 10b. Coun		10c. City, To	own or Location	n				10d. Inside City Limits
8 .]	٦	MD	N/A		Ba	ltimore				1 X Yes 2 No
th the Maryland 13a or 28a-f sho totified at once.	Director	10e. Street and Number				10f. Zip Code		10g. C	citizen of What Co	untry?
th the 23a or	ralDii	2620 Huron				21230			USA	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. Is other than "natural", or items 23a or 28a-f sh. Is the Medical Examiner must be notified at once	Funera	11. Marital Status 1 Never Married 2 3 Widowed 4		2X No	If Ye	Decedent of Hispanic Or s, specify Cuban, Mexica	ın, Puerto Rican, etc.		White, etc.	erican Indian, Black,
urs aftural"	à	15. Decedent's Education (S	or Dates:			Yes 2X No specify s Usual Occupation (Give		16b	Specify: B]	
6 172 ho an "na cal Ex	Completed	Elementary/Secondary (0-1			during mo	st of working life. DO NO	T use retired)		/-	
5-0036 led within 72 tygiene. other than '	틹	0				Infant			N/A	1
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	17. Father's Name (First, Midd Unknown	ne, Last)				er's Name (First, Mid nia Ray	die, Maide	en Surname)	
e, MD 21, and 2 should b Health and Men item 27 is marit	2	19a. Informant's Name/Relation				Address (Street and Nu	mber or Rural Route			
Tore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic	-	Lisa R. Ower	ns/ Grandr			Huron St.	Baltime T Date		MD 212	
F a a a l		1 Burial 2 Cremat		m State cre	matory or othe		6/1/10			
Baltimore, permit. Pages 1 at Department of He. Important: If ite	ł	4 Donation 5 Other 21. Signature of Funeral Servi	Specify: ce Licensee	MC.					ansdown	neral Home
E P P E		Cullen	Hami	9	421	10 Belair	Road Ba	ltim	ore, MD	21206
Physician		 Part I. Enter the disease, failure. List only one cau 		used the death. Do	o not enter the	mode of dying, such as	cardiac or respirator	y arrest, s	hock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disea or condition resulting in death		n Unexp1 consequence of):	ained 1	Death in In	fancy (SUI)1)		Death
	اةِ	Sequentially list conditions, if any, leading to immediate		consequence of):						+
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executed an and al - transit		d.								
O, : be e: siciar	edical	X UNPENDED				er me g906 8	3–17–10 vt			
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the b	ΣΙ	IF FEMALE: 236. If yes, outcome of pregnancy 23d. Date of delivery 23d.						i de la companya del companya de la companya del companya de la co		
, P.O.	by P	Part II. Other significant con-	ditions contributing to	death but not resu	lting in the un	derlying cause given in P	_			the cause of death?
ords, F	ted							yes ∠[Vasan		utopsy findings available
COTC law re has be	Completed				-		a	utopsy erformed?	prior to death?	completion of cause of
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been silted in by the funeral director, page 2 should be		25. Was case referred to medi	cai			26.Place of Death		es 2	No 1 🗸 Y	es 2 No
Vital hysician: this certifi	o Be	examiner? 1 ✓ Yes 2 No	Man-italy -	patient 2 🗸 ER	V/Outpatient		Nursing Home 5	Resid	dence 6 Othe	er:
n of \ding Phy.	٦	27. Manner of Death 1 Natural 5 Death		of Injury 28 Day, Year)	Bb. Time of Inju		_	ibe how ir	njury occurred	-
ision Attence a death ector: by the	catio	Pe	restigation	-19-10 f		20a 1 Yes 2 X	UIIKIIC		and Number of D	ural Route Number, City
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying	•	of my knowledge, examination and/		d at the time, date and pl n, in my opinion, death o	ace, and due to the	cause(s) a	and manner as sta	ted.
F > F 3	ĕ	29b. Signature and title of cert		ited.		29c. License number	ī		I. Date signed (Mo	onth, Day, Year)
	Į	anesz_	-			O.C.M.E.		Ma	ay 19, 2010	
		 Name and address of persons Ana Rubio MD. A 	on who completed cause ssistant Medical E	,		eet, Baltimore, MD	21201			
Sta		31. Date filed (Month, Day, Yea		rar's Signature	1 1					
Regist		JUN (1 2 2010	enera ,		wed				
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10-03927	4.
Joel Otund	е

oel Otunde		State of Maryland / Department of Health and Mental F			17020
		1- For State Certificate of Death	Reg	No.	1020
Physici ledical Exam			2. Date of Death Month E May 22, 201	Day Year	3. Time of Death 0942 hrs
		4a. Facility Name (if not institution, give street and number) 8179 Edge Rock Way #D 306 4b. City, Town, or Location of Deat Laurel	th	4c. County of Death Anne Arundel	
Funeral Director		5. Social Security Number 217-87-3994 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Min		(MM/DD/YYYY) 9. Bird Foreig 2010 Cor	hplace (State or n untry) MD
ih the Maryland 23a or 28a-f show any notified at once.	Director	Usual Residence of Decedent	10g	Citizen of What Cour	10d. Inside City Limits 1 X Yes 2 No
with the N ns 23a or 5 oe notified	ral Dir	8179 Edge Rock Way #D 306 20724 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - Americ	can Indian, Black,
after death al", or iten iner must b	by Fune	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 Yes, Specify Cuban, Puerto 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Specify Cuban,	o Rican, etc.)	White, etc.	ack
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and hendal Hygie with the matural?, or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ref	work done tired)	6b. Kind of Business/li	ndustry
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than	Be Con	17. Father's Name (First, Middle, Last) Eckagnon Joe Otoude 18. Mother's Name Keisha	e (First, Middle, Mai Helm	den Surname)	
MD 21 nd 2 should alth and Me m 27 is ma	2	19a. Informant's Name/Relationship (Type, Print)19b. Mailing Address (Street and Number orEckagnon Joe Otoude/ father8179 Edge Rock Way #	D 306 Lau	urel, MD 2	0724
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Heath and Mental Hygiene Important: Iften 27 is marked other than " injury or other traumatic event, the Medical.		20a. Method of Disposition 1	02/2010	Oc. Location - City or Silver Sp:	ring, MD
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mar 4217 9th St NW Wa Par l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	shington,	DC 20011	
Physician /Medical Examiner		Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sudden unexplained death in infancy Due to (or as a consequence of):		shock, or heart	Approximate Interval Between Onset and Death
	er	Sequentially list conditions, if any, leading to immediate b			
xecuted n and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last certain death (Disease or injury that initiated events resulting in death) Last d.		-	
cian cian	Nedical	X UNPENDED AMENDED 23a.27.28a-f. per ME g908 10/27 IF FEMALE: 23c. If yes, outcome of pregnancy	/10 TT	The Come of Sellings	
Box 68760, e death certificate be ex the attending physician red for use as the burial	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnated by the past 12 months? 1 Yes 2 No 9 Unknown 5 Other (Specify) 9 Unknown	ancy	Month Da	ay Year
P.O.	<u>ā</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the	ne cause of death?
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the finneral director, page 2 should be	Completed		24a. Was an autopsy performe.	prior to co	opsy findings available impletion of cause of
/ital sician:	o Be	25. Was case referred to medical examiner? 1 V vs 2 No Other Nursin		sidence 6 🗸 Other:	Scana
n of \ ling Phy After th	⊢ ŀ	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how		00616
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	Accident Accident Accident Accident Accident Accident Suicide Accident Acciden	28f. Location (Stree	et and Number or Rura	Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		4 Homicide determined (Specify) residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause(s)	8179 Edge Laurel, M	1.
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated. 29b. Signature and title of certifier 29c. License number		place, and due to the	
	-	O.C.M.E.	N	lay 23, 2010	
0		Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MI	D 21201		
Sta	ıtο	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

A. Sark

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Shappley Pinkard 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Rosedale Batt ahare HOS If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Ade (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 11/03/1939 **X**X M 2□ F Days Hours Min. 230-44-0103 Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State 1 ☐ Yes 2 X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. 1618 Williams Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Oil Company Maintenance Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Charles Pinkard Roberta Margaret Stephenson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1618 Williams Avenue, Baltimore, Maryland 21221 Margaret Pinkard (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 06/01/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Future Service Licensee 23a. Part 1. Eight the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only Imme in e Cause (Final dis e or condition resulting in death) 8 Court Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery Month Day Year use contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 6 ☐ Other (Specify)

The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, or Attending Physician: funeral director, After this

Certificat

Physician

Examiner

Director

Funeral

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Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant is notified 21 once.

Physician

/Medical Examiner

Baltimore, Maryland 21215-003

/Medical

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Completed	_`
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To the Hospital or Auson.
within 24 hours after death.
To the Funeral Director: Aft

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pleted by Phy	Par
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Medical

State Registrar

	d							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d	Date of delivery Month Day Year				
Part II. Other significant conditions	ontributing to death but not resulting in the underlying	cause given in Part I.	236. Did tobacco use	contribute to the cause of death				
- Metastatic	Rt ling Cancer	Non Smalle	1 Yes 2 N	o 3 Probably 4 Unkr				
Multiple 1	retastation to bri	ain.	24a. Was an 2	4b. Were autopsy findings avai				
- Coronany	Heart disease,	Afrial fonla	autopsy performed? Yes 2 No	prior to completion of cause death? 1 ☐ Yes 2 ☐ No				
25. Was case referred to me c examiner?	26. Place of Death (Check only one)							
1 Yes 2 No	Hospital: ✓Inpatient 2 ☐ ER/Outpatient 3 ☐ D	OOA Other: 4 I Nursing Hon	ne 5 Residence 6	Other (Specify)				
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury or	ccurred				
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	28f. Location (Street and N City or Town, State)	t and Number or Rural Route Number, tate)					
29a. Certifier Certifying Pt	ysician: To the best of my knowledge, death occurre	ed at the time, date and place, a	and due to the cause(s) an	d manner as stated.				

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1312 Mil) KHIN-M- TUN

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

10-03956		Please Type or Print in Black Indelible Ink. Ensure All Cop	ies Are Le	2010 gible.	17030
Barry Lee Popp		State of Maryland / Department of Health and Mental Hard Registrar State of Maryland / Department of Health and Mental Hard Registrar	Hygiene		
Physic		Decedent's Name (First, Middle,Last)	2. Date of Dea	•••	3. Time of Death
Medical Exam	ine	Dally nee topp	Month May 24, 2	Day Year 010	0450 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 5 Delight Avenue Nottingham	th	4c. County of Dear Baltimore Co	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi 216.84.2043 1 M 2 F 48 Yrs. Months Days Hours Mi		th (MM/DD/YYYY) 9. Bi	rthplace (State or Foreign buntry)
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w any		10a. State 10b. County 10c. City, Town or Location MD Harford Joppa			10d. Inside City Limits
Maryland 28a-f show d at once.	tor	TID TO			1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	I Director	10e. Street and Number 1305 Lake Vista Drive 21085		og. Citizen of What Cou • S • A •	ntry?
th wit ems 2 t be n	iera	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Support of Married Proces? If Yes, specify Cuban, Mexican, Puert	Specify Yes or No-		ican Indian, Black,
after dea ral", or it	by Funeral	3 Widowed 4 Divorced or Dates: 1 Yes 2 No 1 Yes 2 No specify:		White, etc. White Specify:	
hours natur Exam	pe	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use rel	work done	16b. Kind of Business/	Industry
0036 within 72 jene. ner than *	Completed by	12 Laborer		Construc	tion
1215- 1 be filed ental Hyg arked oth	Be	Leroy Popp Joyce	e (First, Middle, M unk		
Baltimore, MD 21215-0036 bermit. Pages I and 2 should be filed within 7 bepartment of Health and Mental Hygiene. mportant: If item 27 is marked other than nijury or other traumatic event, the Medica	To	19a. Informant's Name/Relationship (Type, Print)19b. Mailing Address (Street and Number orJoyce Popp/Step Mother1305 Lake Vista Di	Rural Route Num	per, City or Town, State	, Zip Code) 085
ore, stan of Hea If iter		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
imc. Page ment tant:		4 Donation 5 Other Specify: Chesapeake Crem. 05	.27.10	Beltsvil	le, MD
Salt Separt Mpor		21. Signature of Funeral Service Licensee 7 101443 22. Name and Address of Facility CAI	FA/Step	hen D. Lo	hrmann, PA
Physician	_	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure.	ires DR	BAlto.	
- /Medical	Į	failure. List only one cause on each line.	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Heroin and alcohol intoxication Due to (or as a consequence of):			Death
		Sequentially list conditions, b.			
	ine	if any, leading to immediate Course. Enter Undarlying Course			
E E L	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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760, ficate be exe g physician a the burial -	ğ	AMENDED 23a,27,28a-f,per ME g904 6/8/10 TT			
876 tificat ing phy	<u>Z</u>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancv	23d. Date of delivery	ay Year
Box 68760 e death certificate b the attending physical ed for use as the bu	sician/Medical	4 Pregnant at time of death 5 Other (Specify)		Monar	ay real
that the de red by the detached f	≥L	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Loo sitti		
- 8 20 S	Completed by	establishing to death but not resulting in the underlying cause given in Part I.		acco use contribute to t 2 No 3 ✓ Prob	
Division of Vital Records, P tal or Attending Physician: The law requires the safter death. In Director: After this certificate has been signed be died in by the funeral director, page 2 should be deat in by the funeral director, page 2 should be deat in the funeral director.			24a. Was an		opsy findings available
Reco	Ē		perform	ed? death?	ompletion of cause of
al Fian:	a l	25. Was case referred to medical 26. Place of Death (Check of		10 10 10	2 No
of Vital Reco	P P		g Home 5 R	esidence 6 🗸 Other:	Scene
n of ding I		1 Natural - (World), Day, Fear)	28d. Describe ho	w injury occurred	
isior Attend or death rector: by the	cati	Accident Pending Investigation Fd 5/24/10 Fd 4:45 am Pending Investigation	unk		
Divi	ertification:		28f. Location (Str. or Town, Stat	eet and Number or Run	Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	O F	4 Homicide determined (Specify) house 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and			
To the How within 24 h To the Fur completely		one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	t the time, date an	s) and manner as stated d place, and due to the	cause(s)
F×Fö	ĕ	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mont	h, Day, Year)
4		Panet Douthall, MI) O.C.M.E.	1	May 25, 2010	
10	1	30. Name and address of person who completed cause of death (Item 23a)			
(Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, M 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ID 21201		
Sta Registr		32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygienes of the

Physician
/Medica
Examine

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I as Medical Evaluate that items to incline a once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Stat Registrar

	For State Of Wall	Cer	tificate o				g. No.	UIU	1 /	031	
	Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death										
n	Mabel L.	Pearce			1	May 28,	201	0	4:43	рМ	
il r	4a. Facility Name (If not institution, give street and number)	4b. City, Tow	o. City, Town, or Location of Death 46				c. County of Death				
	346 Leyton Road	Reisterstown Bal					Baltin	ore			
_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 You		r 24 Hrs. 8	8. Date of Birth (Month, Day,	Year)	Cou	place (State	or Foreign	
	219-60-7517 1□M2☑F 9	96 Yrs.	rs. Months Days Hours Min. (Month, May 3)				1, 1913 Maryland				
	Usual Residence of Decedent								d Ord . In mide 4	Oit Limite	
_	100.000	Oc. City, Town or Loc	ation						10d. Inside	•	
cto	MD Baltimore	n	1 ☐ Yes 2 🖸 No								
<u>ir</u> e	10e. Street and Number		10f. Zip Code				10g. Citizen of What Country?				
<u>.</u>	346 Leyton Road		21136				U.S.A.				
Funeral Director	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S. 13. V	13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					o- 14. Race - American Indian, Black, White, etc.			
	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give		1 □ Yes 2 ☑ No Specify:					Specific			
Completed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:					White					
ete	15. Decedent's Education (Specify only highest grade completed)	I (Give I	ent's Usual O kind of work d	one durina mo	st of working		16b. Kind	of Business/Ir	ndustry		
du	Elementary/Secondary (0-12) College (1-4or 5+)	1	O NOT use retired)				0 - 17				
ခြ လ	8	H	lomemak			APP and Address of		own Hom	<u>e</u>		
Be	17. Father's Name (First, Middle, Last)			18. Moti	ner's Name	(First, Middle, I					
ပ	Joseph Edward Ensor							Pere			
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Si	reet and Num	ber or Rural	Route Number	City or	Town, State, Z	ip Code)		
	Jean E. Tolley Daughter		eyton			rstown		21136			
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name on atory or other	f place)	Da	ate	20c. Loca	ation - City or T	own, State		
	4 □ Donation 5 □ Other (Specify)	Bosley C	emeter	7	6/2/2	2010	Cock	ceysvil	1e, MI)	
	21. Signature of Funeral Service Licensee	22	. Name and A	ddress of Faci	ility 118	24 Reis	ters	town Ro	oad		
	Stephen M Her	Kins E	LINE_F	JNERAL	HOME	Reiste	rsto	wn,MD	21136		
	23a. Part 1. Enter the isease, or complications that caused th	e death. Do not ente	er the mode o	f dying, such a	as cardiac or	respiratory arr	est,		Approxim Interval B	ate	
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final		(10 0		1	Dicc			Onset and	d Death	
	resulting in death)	こそいかく そ	CAND	IOVASC	MLAN	D123	ASE	-			
	Due to (or as a consequence of):										
ē	Sequentially list conditions,	ionsequence cf):									
Ē	Sequentially list conditions, if any reading to immediate cause. Enter Underlying Cause (Disease or injury										
xai	that initiated events c c Due to (or as a c	consequence of):									
<u>a</u>											
edical Examiner	d										
100	IF FEMALE: 23c. If yes, outcome of	pregnancy					25	d. Date of deli	verv		
au	in the past 12 months?	Fetal death 3	Ectopic preg					Month Day Year			
/Sic	1 Yes 2 No 9 Unknown	ine or death 3 E	1 Other (apeci	(9)							
Completed by Physician/N	Part II. Other significant conditions contributing to death but I	not resulting in the ur	nderlying caus	e given in Par	tl.	23e. Did to	bacco us	e contribute to	the cause o	f death?	
<u>Ş</u>	ALZHEIMER'S DEMEN		, ,			1 U Y	s 2	No 3□ Pr	obably 4	Unknown	
itec											
헏	CURUNARY ARTERY DIS				autopsy		prior to o	ere autopsy findings available or to completion of cause of			
Š		1			1 ☐ Yes	performed? death? 1 ☐ Yes 2 ☑ No 1 ☐ Ye					
Be (25. Was case referred to medical examiner?				ce of Death	(Check only or	ie)				
<u> </u>		2 ER/Outpatien	t 3□ DOA	Other: 4 🗆	Nursing Hon	ne 5 Resid	ence 6	Other (Spec	cify)		
Ë	27. Manner of Death 1 ★Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, 1)	28b. Time of Injury	28c.	Injury at Work?	2	8d. Describe h	ow injury	occurred			
aţ	2 Accident investigation		M	1 ☐ Yes 2 ☐ No							
<u>=</u>	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.				et, factory, office 28f.			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Ç											
Medical Certification: To	a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [Check only] [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
g	one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
ž	29b. Signature and title of certifier						signed (Month, Day, Year)				
	MA M.D	D0059107				06-01-2010					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
	KALU UMA 210 BUSIN	ESS CENTS	R DR	VE R	EISTS	ERSTON	N	MD	2113	36	
е	24 Date filed (Month Day Vear) 32 Remichar	s Signature									
ır	JUN 0 2 2010 Zerses	1 1 1	backer	•							
01	JUNUZ ZUIU / CEREC	~ p. 19				-					

			Please	Type or Pri						_	ole.		
			For State Registrar	State of M	arylani	•	tificate of	Health and Death	мента пу	Reg. No.20	0 17032		
I	Physicia Medic		1. Decedent's Name (First, Middle, Las		A. I	Parron			2. Date of De Month	Day Ye	3. Time of Death SiSG PM		
	Examin		to the state of th										
	Funeral		5. Social Security Number 6. S			ast birthday)	If Under 1 Year Months Days			th 9	. Birthplace (State or Foreign		
	Director		213-42-2832 1 Usual Residence of Decedent	M ZAI	66	Yrs.			DEC 26	, 1943 N	laryland		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. County N/A	1	10c. City	, Town or Loc	Baltim	ore			10d. Inside City Limits 1 X Yes 2 □ No		
:		Dire	10e. Street and Number			10f. Zip Code					10g. Citizen of What Country?		
3		Funeral Director	3206 Ellerslie				21218		USA				
(0			11. Marital Status 1 Never Married 2 Married	Armed Forces?	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates.		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 【XNo Specify:			14. Race - American Indian, Black, White, etc.			
21215-0036		ted b	3 Widowed 4 XDivorced	If Yes, Give Year or Dates.						Specify: White			
-215		To Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)			(Give F	lent's Usual Occu kind of work done D NOT use retired	during most of wo	rking	16b. Kind of Business Industry Stationary			
212			10	College (1-4 of C)+)]	Machinis	Т'''		Manufact	urer		
land			17. Father's Name (First, Middle, Last) Arthur	C. Bi	tzer			18. Mother's Na		Maiden Surname)	Adkins		
Maryland			19a. Informant's Name/Relationship (7	ype, Print)		}	_			ar, City or Town, State			
e, ≥			Joan L. McBride,	sister	20h. Pl		Forest sition (Name of	Drive !	Deland,	FL 3272			
mor	rage I nent of int: If it		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Ce	emetery, crem	natory or other pla	Inc. 06/0			ore, MD		
Baltimore,	Departm Departm Imports any inju		21. Signature of Funeral Service Licens	George V	lacNal	bb 22	. Name and Addr	ess of Facility C:	remation	Society	of MD, Inc.		
	20 = 6 0		23a. Part 1. Enter the disease, or com	dications that caused	d the death			erick Roa ng, such as cardia		imore, MD	Approximate		
₽	Physician/										Interval Between Onset and Death		
1	Medical xaminer	Day to (b) as a serior dance of											
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. ————————————————————————————————————									
1		Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c Due to (or as	Due to (or as a consequence of):								
0		ਲ	Codding in doubly Educ	d									
68760		/Med	IF FEMALE:	00-14									
Box 6		Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1						23d. Date of Month				
O. E		Phys							23e Did t	obacco use contribu	to use contribute to the cause of death?		
s, P.O.		d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1										
Division of Vital Records,	s been 2 shoul	ate: To Be Completed by								re autopsy findings available or to completion of cause of			
Rec	cate has								perfo 1 ☐ Yes	ormed? dea	th? Yes 2 No		
/ital	Hospital or Attending Physiciam 24 hours after death. Funeral Director: After this certificieted filled in by the funeral director		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ient 2 🔽	ER/Outpatien	Ot	Place of Death (Chener:		dence 6 Other (Specify)		
of of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (28a. Date of injury (Month, Day, Year) 28b. Time of injury work? 28b. Time of injury at work?									
sion		Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office			28f. Location (Street and Number or Rural Route Number,						
Div.				building, etc. (Specify) City or Town, State)									
H		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
- F	within To the	2	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed (A	fonth, Day, Year)		
			30. Name and address of person who	Completed cause of d	leath (Itam	23a) /Timo []		1715		3/17	1010		
	ÔV		Ruff Guant			FAUS		BARTIA	ropé,	ms 2/2/1			
	Stat Registra		31. Date filed (Month, Day, Year) JUN 0 2 2	32. Registra	ar's Signati	ure.	arkel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Raymond Quigley 2010 1:16 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Woodbridge Valley Catonsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 X M 2 ☐ F Months 025-22-1371 Director 81 NOV 6. 1928 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Important: If Item 27 is marked other than "natural", or items 23a or 28a-5 show any Injury or other traumatic event, It "Medical Essimitation and the nutrited at 10a. State 10c. City, Town or Location event, tre Medical Examiner must be notified at 10d. Inside City Limits Director MD Baltimore Catonsville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? S. Belle Grove Road 107-A Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Affried Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Co Pilot US Air Force 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Unk. Quigley ျှ Margaret Carney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David E. Quigley, son S. Belle Grove Road Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 05/29/10 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNah 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LEFT LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed y physician and is the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical attending phase as the 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed cate has t page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 □Yes 1 Tyes Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 ☐ Residence 6 ☐ Other (Specify) s after death. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ō To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRENEZEN DVAINOD WWS 3350 WILKENS AVE #307 BALT. NW 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

アインアンシウ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Arline Marie Rice Month Physician/ 7:10 P M 2010 Mav Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Ctr. Baltimore City 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Social Security Number 023-12-565] Days Month, Day Ye Dec. 22 1 M 2 1 F Months Hours 1923 Massachusetts 86 Yrs Director Usual Residence of Decedent shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Dundalk .28a-f 1 Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral United States 21222 4124 Eder Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify 3 X Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry J. Lacourse Catherine E. Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth a Important: If item 27 is any injury or other trai Dorothy R. Gephardt (Daughter) 4124 Eder Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cem. 5/27/2010 Baltimore, Maryland 21. Sign vur of Funeral Service Licens Duda-Ruck Funeral Home of Dundalk, Inc. <u>7922 Wise Ave.</u> Dundalk, Maryland art 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as comiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) ME Medical Due to (or as a cons of ence of) **Examiner** Sequentially list conditions. Due to (unas a consequence of) cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed sician and bunal-trans that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a as the bunal-/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ fr use 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Year Day Pregnant at time of death Other (specify) 9 Unknown g Unknown P.O. β signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 Munknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director; After tompleted filled in by the funera 28d. Describe how injury occurred Natural injury 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 2205 York Road Suite

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Maryland

Timonium,

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :35 PM 2 abe Medical 4c. County of Death 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Bon Secours Hospital Baltimore 8. Date of Birth (Month, Day, Year) 10/30/1919 Birthplace (State or Foreign Country)
 CC 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Months Min. Days Hours 1 □ M 2 😾 F SC 90 Director 247-18-6329 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director Yes 2 ☐ No N/A Baltimore MD 10e. Street and Number 10g. Citizen of What Country? Funeral 21216 U.S.A. 2201 Walbrook Ave., Apt.G01 items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Margaret Bennett pernit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me entary/Seconday (0-12) College (1-4 or 5+) 5th Grade cook Girls School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Madden Anna Johnson Gus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5614 Groveland Ave., Balto., MD 21215 Barbara Turner (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 06/05/10 Woodlawn, Woodlawn Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Joseph H. Bro Brown Jr. Funeral Fulton Ave. Balto., Home MD 21217 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Chemic Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Die to (or as e nonsequence of) Exami the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physiclan I for use as the burlal Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown To the Hospital or Attending Physician; The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Tes 2 No 1 Napatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 2 Accident 3 Suicide 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 29c. License number of person who completed cause of death (Item 23a) (Tybe, Print) 2000 West Baltimore Street, Baltimore, Hayland, 21223 Cú V.00

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Regi**e**rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) KOBINSON Physician/ MAIDY 3 pay 15120 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 75 Yrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month Day, 1 **№** M 2 🗆 F Director r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Baltimore 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 21229 USA Funeral within 72 hours after death with Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 2 should be filed within 72 l th and Mental Hygiene. ?7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) lexk Be er's Name (First, Middle 18. Moth 17. Father's Name (First, Middle, Last) ion Kobinson Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Ellen Baltimore, 20b. Place of Disposition (Name of demetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Division of Vital Records, 1 ☐ Yes 2 ☐ No cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 5 Pending 1 Natural 2 No within 24 hours after death.

To the Funeral Director: A: completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL 05 301 TH 31. Date filed (Month, Day, Year, 32. Registrar's Signatur State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#3perPHYS, G904 6/11/2010 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robin son Physician/ EVELYN Day Month Year 4: 15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Randallstown Baltimore 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) Director SC 213-18-7682 Usual Residence of Decedent f show 10a. State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1600 West Mount Royal Ave U.S.A 12. Was D 11 Marital Status ecedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: 3√ Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade na Beautician Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Shaw Elizabeth Eggleston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Shirley Keene-Daughter 3904 Susanne Road, Randallstown, Md 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) cemetery, crematory or other place) Calvary 6/5/2010 Baltimore, Md 21 30 Name and Address of Eacility
March F/H West
4300 Wabash Av of Funeral Service Lice Gee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

District Cancer Baltimore, Md 21215 Interval Between Onset and Death Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other:
4 \(\text{Nursing Home } 5 \(\text{D Residence } 6 \(\text{DOther} \) (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 🚅 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the vithin 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MS Rajapaksem. D D0057465 5127/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NIS. RN APAKSE/M'D 2835 Smith 2835 Smith Avenur-5-235- Baltimore, MD, 21209

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Year Physician/ Rashada Talib 05 26 2010 7:00p Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard 5627 Columbia Columbia a Road 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 X M 2 🗆 F Months Director 224-90-2426 09 08 ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c City Town or Location filed within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 XNo Columbia Howard MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21044 5627 Columbia Road iral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: Black 3 Divorced "natural", Completed th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Self Employed 12th grade Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Heatth and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine W. Myers Warren C. Dunn Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5627 Columbia Road, Columbia, Md 21044 Kim Rashada-Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State rlayn Gardens 4 Donation 5 Other (Specify) 5/29/2010 Harrisonburg, Funeral Service Lice Name and Address of Facility larch F/H West 4300 Wabash 212115 Baltimore, Md Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final ardiac Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner sequence of Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death ed by the a g Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No this certificate has death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending 1 Yes 2 No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) ٥ 2016 28 5500 Knoll North Deive Columbia MD who completed cause of death (Item 23a) (Type, Print) ROCOVA

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ritz 2010 Medical 26 5:50 АМ May 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8207 Peach Orchard Road Dundalk If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours 203-16-6016 (Month, Day, Year) Country)
September 21, 1926 Pennsylvania Director 83 Usual Residence of Decedent 23a or 28a-f show 10a. State filed within 72 hours after death with the Maryland al Hygiene. Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Dundalk 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8207 Peach Orchard Road 21222 USA items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces . O. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes 2 No "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Wildowed 4 Divorced Specify: White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry other than Elementary/Seconday (0-12) College (1-4 or 5+) the 10 years Undisclosed Federal Government Be it. Page 1 and 2 should be filed rtment of Health and Mental Hy rtant: If item 27 is marked off njury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Calvin McCollum Sallie Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Roudebush Daughter 8207 Peach Orchard Road, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 27 ☐ Burial 2X Cremation 3 ☐ Removal from State Donation 57 Other (Specify) Bayview Crematory 2010 Baltimore, Maryland 21. Signature of Fun ^{22. Name and Address of Facility} Connelly Funeral Home Of Dundalk, P. 7110 Sollers Point Road, Dundalk,MD. 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Immediate Cause (Final Physician, Onset and Death disease or condition resulting in death) Medical onsequence of Examine Sequentially list conditions, Due to (or as a consequence or): cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) cal Division of Vital Records, P.O. Box 68760 Physician/Medi 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Day Year been signed by the sahould be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes ØNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s page performed Yes this certificate 2 🗌 No 1 Tyes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred Natural 5 Pending work? after death

Director: A

in by the f 2 🔲 No Accident Investigation To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29b. Signature and title of certific 30. Name and address of person Blyd. Point 06 31. Date filed (Month, Day, Year) JUN 02 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 27, Physician/ 2010 Weir Robinson 7:34 a. M Anna Marion Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** New York Days Sept. 21 Hours Min. 1 M 2 X F 96 **Director** 579-42-1182 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho ant: If item 27 is marked outher than "natural", or items 12a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 🗌 Yes 2 🔀 No Montgomery Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20815 8700 Jones Mill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ⚠ No Black, White, etc. \$ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marion Elizabeth Bills Samuel Weir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1900 M. St., N.W., Suite 600, Washington, DC 20036 Michael F. Curtin (Attorney) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of F
Important; If ite
any injury or ot May, 1 Burial 2 XX Cremation 3 Removal from State Beltsville, Maryland 29, 2010 Chesapeake Crematory ! 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Sign sure of Funeral Service Licensee 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death years Immediate Cause (Final Atherosclerotic Cerebrovascular Disease Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 No certificate has been signed by the irrector, page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Dementia, Dysphagia, 1 Yes 2 No 3 Probably 4 Unknown Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pneumonia, Hypertension autopsy performed? 1 ☐ Yes 2 ☐ No 2 🔀 No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; § Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner?
1 \(\subseteq \text{ Yes} \quad 2 \) \(\frac{\text{X}}{\text{No}} \) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check I Certifying Nurse Practioner: To the best of my knowledge, death accumed at the time, date and place, and due to the desire's and n 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number May 27, 2010 D53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan, M.D. 9801 Georgia Ave. Suite 117, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's signature State back IIIN 0 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a b per doc 9904 6-2-10 vt amend items tate of Maryland Department of Health and Mental Hygiene Certificate of Death 1 - State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 4/14/2010 2:55pmM Squire Maggie Ray Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number)
Paradise Assisted Living Baltimore Examiner Catonsville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Age (In yrs. last birthday) (Month, Day, Year) 5/14/1933 Hours Social Security Number 241-52-5821 **Funeral** 1 🗆 M 2 🏲 F Months Days NC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 10a. State other traumatic event, the Medical Examiner must be notified at with the Maryland Catonsville Director XX Yes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 23a or USA 21228 Be Completed by Funeral 6348 Frederick Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Black, White, etc. 11. Marital Status Armed Forces?
1 ☐ Yes 24 No
If Yes, Give 1 Never Married 2 Married black 1 Yes 2 No Specify: ò Maryland 21215-0036 3 Widowed 4 Divorced "natural", Year or Dates 16b, Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) Public schools Elementary/Seconday (0-12) d Mental Hygiene. marked other than College (1-4 or 5+) teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernice Williams ပ္ Valve Squire 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and lis m 2032 Kennicott Rd., Windsor Mill MD 21244 Nephew Patillo / Randy item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of Baltimore, 20a. Method of Disposition Gaston Baptist Church Cem 4/19/1 Department of P Important: If ite any injury or ot once. Gaston, 1 Burial 2 Cremation 3XXRemoval from State 4 Donation 5 Other (Specify) 22 Name and Address of Facility Charles L. Stevns Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 of Funeral Service Licensee Victor P. Doda 21. Signat Olca 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Anemia Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) years Hypertension **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Month Day in the past 12 months? 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown δ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The law performed' 200 No 1 Tyes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Assisted Be Other: examiner? 4 Nursing Home 5 Residence Other (Specify) Living Home 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 🗌 Yes 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death injury 1XXNatural 5 Pending 1 Tes 2 No Investigation 6 Could not be 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Homicide 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) Date signed (Month, Day, Year) 29c. License number nd title 29b. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month. **Physician** 2010 Shaver 'ci'a /Medical City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kocknille Social Security Rumber 8. Date of Birth (Month, Day, Year) 12/14/18 If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav **Funeral** Hours 91 Months Days CT1 ☐ M 2 🖼 048-10-5468 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Martin. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Falls Church Yes 2 No VA Falls Church City Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22046 USA 2612 Sigmona Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3altimore, Maryland 21215-0036 ģ 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melville Ellen Burke Scott Kane 2 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 107 Fayette Street, Watertown, MA 02472 Son Robert Scott Shaver 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Anthony Cemetery Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 6/5/2010 CI Litchfield, 4 Donation 5 Dother (Specify) Charles L. Stevens Funeral Home, Inc 1501 E. Fort Ave, Baltimore MD 21230 21. Signature of Funera Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** NE ICM Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ■ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform 2 No 2 No 1 ☐ Yes 1∏ Yes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Hospital: 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2**X** No 2 ER/Outpatient 1 Inpatient ဥ 1 ☐ Yes this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0062435

State

State 31. Date filed (Month, P

32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Jarle

lay Dr. Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month VIRGINIA MRI 10:00 AM Medical 4a. Facility Name (if not institution, WNIVERS ITY OF I stitution, give street and number of MARY LAND 4b. City, Town, or Location of Death BALTIMORE Examiner 4c. County of Death MEDICAL CENTER N/A 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/24/1941 9. Birthplace (State or Foreign 1 M 2 XF Director 215-40-5780 Country Maryland Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified MD N/A Baltimore 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1320 N. Fulton Avenue 21217 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. þ 1 X Never Married 2 Married Yes 2X No Maryland 21215-0036 If Yes, Give 1 Tes 2 No Specify: 3 Divorced 4 Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9th <u>Grade</u> Custodian Hilton event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. Aubrey Shaw Annie Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Shaw (daughter) 3735 Raspe Ave., Baltimore, MD 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 06/04/10 Lansdowne, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility

Joseph H. Brown Jr. Funeral Home, PA
2140 N. Fulton Ave., Baltimore, MD 21217 inus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ETASTATIO manths Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day Year the 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Other: this 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Investigation 1 🗌 Yes 2 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) edical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1134354269 30 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINETOU FAZL, UNIVERSITY OF MARYLAND MEDICAL CENTER, BALTIMORE, ME 31. Date filed (Month, Day, Year) State 32. Registra Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Deloris Hope Smith 27, 2010 8:05 A May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 633 California Terrace Gambrills Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) Year **Funeral** Months Days Hours Min. 1□ M 25 F Virginia 15. 1924 West 86 Feb. Director 236-54-3238 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f show Examiner is ust be notified at 1 ☐ Yes 2X No Buffalo West VA Putnam Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 25033 Route 1, Box 314 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 C No Specify: þ 3 Ø Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 4+ Elementary/Secondary (0-12) Education Teacher is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Lee Null Roy Frank ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any Injury or other trau once. 633 California Terrace; Gambrills, MD 21054 Daughter Elaine Shai 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Buffalo, West Virginia 6/2/2010 Gardenview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fungral Service Licer 1630 Edmondson Avenue; Catonsville, Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Immediate Cause (Final disease or condition resulting in death) ear ongestive **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, isaming to him adulticase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a nonsecuence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 7 4 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl autopsy 1 Tyes this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Daughter Other: 4 Nursing Home 5 Residence Hospital: 6 Mother (Specify) Resident 1 🗌 Yes 2 **4**00 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide thin 24 hours after the Funeral Dire mpletely filled in t 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 2 To the I complet

State Registrar 29b. Signature and title of certifier

32. Registrar's Signature 31. Date filed (Month, Day,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gorbaly

DHMH 17 Rev 1/2001

ORIGINAL.

29c. License number

29d. Date signed (Month, Day, Year)

					idelible Ink. Ensure	-					
		•	For State Of IVIA State Registrar		artment of Health and I tificate of Death		3. No? 010 17045				
	Physicia Medic		1. Decedent's Name (First, Middle, Last) CARLTON	SUMM	ONS	2. Date of Death	- 222				
4	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death Baltimore		4c. County of Death				
	Funeral			(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign country)				
	Director		213-36-4840	59Yrs.	World Will.	09 24	40 VA				
	fand f show d at	tor		10c. City, Town or Loc			10d. Inside City Limits				
	e Mary r 28a-i notifie	Direc	MD NA 10e. Street and Number	Balti	more 10f. Zip Code	100	1 「▼Yes 2 □ No g. Citizen of What Country?				
	with th	eral	1511 North Payson Street	et	21217	100	U.S.A.				
	death r items iner m	/ Fun	11. Marital Status 12. Was Decedent Ev	er in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.				
920	rs after rral", o Exam	ed by	1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates.	.0	Yes 2 X No Specify:		Specify: Black				
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner must be notified at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation kind of work done during most of work ONOT use retired)	king 16	6b. Kind of Business Industry				
212	within giene. er thar , the N	Con	Elementary/Seconday (0-12) College (1-4 or 5+	.)	onstruction Wo	rker C	City of Baltimore				
and	ntal Hy ed oth event:	To Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Mai	•				
Maryland	2 should be filed within 72 h and Mental Hygiene. '7 is marked other than "traumatic event, the Med	ľ	Alexander Summons 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin		Anderson al Route Number, Ci	ity or Town, State, Zip Code) 21217				
	and 2 sl Health a tem 27 i		Doreatha A. Davis-Friend		North Payson						
nore	Page 1 a nent of H ant; If ite ary or ot		20a. Method of Disposition 1		sition (Name of natory or other place) 1 Forest Vet 6		Oc. Location - City or Town, State Owings Mills, Md				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	H	21. Signatur : (Funeral Service Licensee)		Name and Address of Facility Arch F/H West	/0/201p	Owings Hills/ Hd				
8	8 2 E 6 9	5 05	23a. Part II. Enter the disease, or complications that caused to	4:	300 Wabash Ave						
	Physician/		shock, or heart failule. List only one cause on each line.			or respiratory arrest,	Interval Between Onset and Death				
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a limit of the condition of the	consequence of):	1 0						
	LXammer	ıer	Sequentially list conditions, if any, leading to immediate	stage 12	enal discuse						
3.	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events	pertensi	ión		t .				
	be executed sician and burial-transit	ä	resulting in death) Last Due to (or as &	consequence of):							
Box 68760	ificate t ig phys as the l	Physician/Medio	d.								
39 X	ith cert	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 ☐ Live Birth 2	Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year				
Bo	the dea by the a ached f	hysic	1 Yes 2 No 9 Unknown	ime or death 5 L	Other (specify)						
, P.O.	s that tigned b	by	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death? 2 🔀 No 3 🗆 Probably 4 🗀 Unknown				
ords	require been si should	Completed		AARTYL		1 Yes	24b. Were autopsy findings available				
3ecc	he law ite has	dwo				autopsy performe	prior to completion of cause of				
tal	ician: T	Be	25. Was case referred to medical examiner?		26. Place of Death (Chec						
of V	g Phys er this eral dir	e: To	1 ☐ Yes 2 ☐ NO 1 ☐ Inpatier 27. Manner of Death 28a. Date of injury	nt 2 ER/Outpatien 28b. Time of	28c. Injury at	ome 5 Residence 28d. Describe how	ce 6 Other (Specify) injury occurred				
ion	tending leath. tor: Aft the fun	ificat	1 Natural 5 □ Pending (Month, Day, 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be		work? 1 ☐ Yes 2 ☐ No						
Division of Vital Records,	al or At s after o l Direct d in by	Cert	4 ☐ Homicide determined 28e. Place of Injurbuilding, etc.	y - At home, farm, stre (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)				
Ц	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bur	Medical Certificate:	29a. Certifier 1 Certifying Physician: To the best of m (Check 2 Medical Examiner: On the basis of examiner)	amination and/or invest	igation, in my opinion, death occurred a	at the time, date and	place, and due to the cause(s) and manner stated				
	Fo the land within 2 of the land completed	Me	only one) 3 Certifying Nurse Practioner: To the be 29b. Signature and title of certifier	est of my knowledge, o	death occurred at the time, date and pla 29c. License number		ause(s) and manner as stated. d. Date signed (Month, Day, Year)				
			V. Mikdashims		D0038046		5/23/2010.				
	241		30. Name and address of person who completed cause of dea U. W. K. Las L.: W. 2 DO 31. Date filed (Month, Day, Year) 32. Register JUN 0 2 2010	ath (Item 23a) (Type, P O WŁOŁ	Bultimore stre	et Ba	UtimenMD 21223				
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	barre						
		.00	ADDIT OF THE OWNER OWNER OF THE OWNER OWNE								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ Mith Scilla 2010 16:15 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore Parksley <u>Ave</u> 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral Months Hours Min. 09 24 Year) Country) 1 □ M 🛠 🗆 F Director 53 219-66-9227 Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10a. State 10b. County 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21223 532 Parkslev 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give þ 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black 3 - Widowed 4 - Divorced Completed Year or Dates and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical B 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Md Elementary/Seconday (0-12) College (1-4 or 5+) Shock Trauma <u>Trauma Technician</u> <u>12th grade</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ruby Smith traumatic Thomas Johnson Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trac John D. Fulton III-Son Parksley Ave, Baltimore, Md 21223 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 6/5/2010 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service i 22. Name and Address of Facility
March F/H West
4300 Wabash Av Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final a Physician sculitis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to true ediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a nonsectionne of: attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death the detached Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 1 Yes 2 No Yes 2 No ours after death. **neral Director:** After this certifier ifilled in by the funeral director, i Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 Natural 2 Accident 3 Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the l within 2 To the f only one) 29b. Signature and title of certifier D67356

State Registrar ATRINA

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

UNIVERSITY FAMILY MEDICINE

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FWW, M.D

Regist

r's Signature

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2010^{Year} May Physician/ 31 $1:15p^{M}$ Charlotte Sherrill Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Co. Dundalk 3132 Sollers Point Road 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Hours 8 Mozt 2 Day 1 9 3 2 Delaware 222-18-1013 77 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 No MD Baltimore Co. Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 3132 Sollers Point Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White 3 → Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (3-4 or 5+) Medical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anna Leyko Walter Sniadowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Padilla-Daughter 3132 Sollers Point Road Dundalk, MD 21222 20b. Place of Disposition (Name of 20c. Location - City or Town, State 6-3Pag 010 Department of I Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Sacred Heart of Mary Cem. Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ hear disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner en per Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus 3 Probably 4 Unknown 1 Yes 2 No director, page 2 should peen 24b. Were autopsy findings available 24a, Was an To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director: After this certificate has the completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No prior to completion of cause of death?" 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) June 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Suite 224. Towson MD 7801 York Rd. Newill 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Rea. No 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 May Month Physician/ 26 4:15pM Smith Linda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dunda1k Baltimore Co. 7848 St. Clair Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth 4 – 2 7 – 1 9 4 5 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖺 F Hours Maryland 65 212-44-7797 Director Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medi. al Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Dunda1k Baltimore Co. MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 IISA 7848 St. Clair Lane death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Seconday (0-12) Home Homemaker 10 permit. Page 1 and 2 should be filed wit.
Department of Health and Mental Hygies
Important: If item 27 is marked other I
any injury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Doris Gurry Hillary Larkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21221 Middleborough Road Essex, <u> Robert Smith - Son</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Haven Cemetery 5-28-10|Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Roberd 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician. CELL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Dunité (or six à nonsequence of) If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burial physician s the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE nse 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 LI Fetal Qua Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown 2 🗆 No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has performed nin 24 hours after death.

the Funeral Director: After this certificate hapleted filled in by the funeral director, page Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \) Residence \(6 \) Other (Specify) 1 Tyes 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Accident 2 ☐ Accider 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical I (Check Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) HOO erson who completed cause of death (Item 23a) (Type, Print) 9110 PHILADELPHIA RD STE 314 BALTO.

State Registrar 31. Date filed (Montl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#18perFH, G904, 6/8/2010, WS
State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Smith, Sr. Month 2:45 AM Sheridan Wayne ,2010 Ma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1909 Letitia treme If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 X M 2 □ F 212-40-1592 67 Months Hours Min. 07/25/1942 Country) **Director** MD Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland Director Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 Funeral 1909 Letitia Avenue **USA** Page 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Optician Healthcare and Mental Hygien is marked other tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Edna Ballister Ballenger ပ George Hamilton Smith Sr. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1909 Letitia Avenue, Baltimore, MD 21230 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau once. Rosemarie Smith / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey Crem. 1 Burial 2 Cremation 3 Removal from State 5/29/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Signature of Funeral Service Licensee Dorota Marshall W Marshall Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on expline. Approximate Interval Between nset and Death Immediate Cause (Final Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Éxaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 🗌 Yes After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: **X** Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Funeral Director; A Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State Medical 29a. Certifier 1 📉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29c. License number D/SS87 29b. Signature and 29d, Date signed (Month, Day, Year) and address of mrso who complet d cause of death (Item 23a) (Type, Print) Ave Boltimore 31. Date filed (Month, Day, 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Vear **Physician** 418 Mar 2010 Wayne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Harton Itarford Memorial Hospital Harrede Grace If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number ge (In vrs. last birthday) **Funeral** Months Days Hours 04/08/1945 1**X** M 2□ F 226-58-5730 65 Yrs. VA Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State 28a-f show Department of Heelth and Mental Hygiene. Important: If Item 27 is merked other then "natural", or items 23e or 28a-f show any Injury or other traumetic event, the Medical Evanment must be notified at once. MD Harford Harve de Grace 1XYes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 709 Earlton Road 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Mayes 2 No
If Yes, Give US Navy
Year or Dates: US Navy 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer US Navv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond E. Stanley Iola (unkn.) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stanley / Spouse Mary 709 Earlton Road, Harve de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/1/2010 Final Journey Crem. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall PO BOX 1413, Baltimore, MD 21203 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (andiomy opath **Physician** disease or condition resulting in death) /Medical Due to (or as a conse hen e of): Examiner disease arte oronam Sequentially list conditions, if any, leading to immediate cause. Error or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KER/Outpatient 3 □ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 Yes 2 Accident efter death Director: 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Hospital Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D69196 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who c Ave Harrede Grace iMD Fife SOI S. Unian

State Registrar

te 31. Date filed (Month, Day, Yea

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ E. 2³2 20**1**0 Sadler 8:50a M Florence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manchester 3607 Rockdale Road 8. Date of Birth (Month, Day April 10 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 □ м 2 🛣 Б Months Hours Director 212-32-403<u>0</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 28a-f 1 🗌 Yes 2 😾 No Carroll <u>Manchester</u> Marvland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number items 23a or ner must be n Funeral 3607 Rockda<u>le Road</u> 21102 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?, 1 ☐ Yes 2 ☐ No Black, White, etc. ò ģ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify White Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Black and Decker Machine Operator 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Minnie Mae Louis Adam Denmead Kelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a 3607 Rockdale Road, Manchester, Maryland 21102 Sandra Blair, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a, Method of Disposition Department of I-Important: If ite any injury or oth 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Metro Crematory, Inc. 05/31/2010 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Signature of Funeral Service Licensee George MacNabb 299 Frederick Road Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ erephovese disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Ol o have Sequentially list conditions. Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 4 pertension for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last s been signed by the attending physician should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 1 L Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Lunknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed After this certificate 2 UN 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 WNO Other: 4 Nursing Home 5 Residence 6 Other (Specify, ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending 1 Natural work 1 Yes 2 No Accident
Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29d. Date signed (Month, Day, Year) nd title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13. Laneua Lamar 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8:38 **Physician** 29 2010 Howard Schafer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HUSPITAL -TIMOR HGNES N/A 8. Date of Birth (Month, Day, Year) 01/23/1928 Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral Days 1**X** M 2□ F Maryland Director 218-81-2136 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int; If Item 27 is marked other than "natural", or items 23a or 28a-f show 10h. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examination continued on ceiling and 1 XYes 2 □ No Director Baltimore N/A 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 21223 1823 Wilhelm Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1XYes 2 No 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 TXNo Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Produce Sales Food Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Sadler Howard Schafer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3300 Benson Avenue Apt. 206, Baltimore, MD 21227 permit. Pages 1 and:
Department of Health
Important: If Item 27,
any Injury or other tr.
once. Mrs. Pearl Rodriguez (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Denoval from State Loudon Park Cemetery 06/02/2010 | Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 1. Signatur - of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 No 1 □Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tiple of certifie 23768 05, 29, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD, 21229 900 CATON AVE, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registra Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Physician. Medical MAY 2010 5:00P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2903 FALLSTAFF ROAD BALTIMORE N/A **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 93 Country) Director 232-14-5803 0877977976 MD Usual Residence of Decedent 10a. State with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits must be notified MD N/A 28a-f BALTIMORE 1 X Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2903 FALLSTAFF ROAD, #308 21209 USA items death 1 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Armed Forces?

1 Yes 2 No 14. Race - American Indian or. 1 Never Married 2 Married filed within 72 hours after þ Black, White, etc. Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Completed 3XXWidowed 4 □ Divorced Al Hygiene. J other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES MANAGER RETAIL Be f and 2 should be of Health and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHARLES LOWE ANNA MEYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVE SUSSMAN/NEPHEW 1539 MIDDLE RUN DRIVE, FINKSBURG, MD 21048 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: Baltimore, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHIZUK AMUND CONG. 05/30/2010 BALTIMORE, MD Donation 5 - Other (Specify) of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Physician, Onset and Death disease or condition resulting in death) Medical onsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events. Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): for use as the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year the 9 Unknown been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has [page performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? ျှ 1 🗌 Yes 2 No Other 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? Investigation 2 🗌 No within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medieal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Petitying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler (Check 3 [only one 29b. Signature 30. Name and rson who completed cau death (Item 23a) (Type, Print) HALLAN 31. Date filed (Month, Day, Year) State 32. Registra 's Signature Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) CHARLES J. SMITH JR. Physician/ MAY 29^{ay} 2010^{ea} а м 1:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pasadena Anne Arundel 200 Inverness Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Min. Maryland 1 🗷 M 2 🗆 F 69 216-38-3533 March Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Anne Arundel 1 🗌 Yes 2 🗷 No Pasadena Maryland 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code Funeral 200 Inverness Road 21122 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Yes 2 X No Yes, Give 1 Never Married 2 Married þ Specify: White Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bordens Ice Cream Co. 0 Mechanic marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Pless Catherine Charles J. Smith Sr. and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 200 Inverness Road, Pasadena, Maryland 21122 Nancy L. Smith (Wife) Baltimore, 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State New Cathedral Cemetery June 3, 2010 |Baltimore, Maryland 4 Donation 5 Dother (Specify) 2. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 2004 Mountain Road, Pasadena, Maryland 21122 . Signature of Functul Service License art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I mediate Cause (Final HEPATOLECL ANCINOMA Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, Examil attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn and the page 2 should be detached for use as the burn and the page 2 should be detached for use as the burn and the page 2 should be detached for use as the burn and the page 2. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Yes 2 No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie DU66107 MYSICIAN 30. Name and address of person who completed cause of death LINIVERSIM Manylea 21072 31. Date filed (Month, Day, Year) Registra State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#16b, perFH, G904, 6/2/2010, Ws
State of Maryland / Department of Health and Mental Hygiene 2 | | | For State Registrar Certificate of Death Reg. No. 3. Time of Death
4:38 P_M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ louchavel JR 28 2010 Albert William Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rollina Baltimons Baltmore Count If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 217 186660 Months Days Hours Min. March 30, Maryland 87 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🎦 No MD Catonsville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21228 1450 North Rolling Road USA ural", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White er than "natural", or, the Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Constuction 12 Mechanical Contractor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 2 William A. Touchard, Sr. Emma Meagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian J. Touchard 29377 Whitetail Drive; Cordova, MD 21625 Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ew Mem. Park | 6/2/2010 | Sykesville, MD | 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. | 1630 Edmondson Avenue; Catonsville, MD 21228 enter the mode of dwing such as are less than 1830 Edmondson. Lake View Mem. Park 4 Donation 5 ☐ Other (Specify) Sign Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death estros Immediate Cause (Final Physician/ Heart CONG yalex disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner acer. Imoncer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a detached f 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X N 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 \(\text{Yes} 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 KResidence 6 Other (Specify) ျှ this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28c. Injury at work?
1 ☐ Yes 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural iniun 5 Pending Accident 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I-within 2, To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RO51063 Maericar 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) Raws Block Mark ON Kelley CLOP VA 3900 Lock Raws Block BaltinoxE MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician**)25p ZOIL brothi MOCHINO /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs, last birthday) **Funeral** Months Days Hours 1 M 2 M 430-44-7885 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 1 Yes 2 No ems 23a or 28a-f sh r must be notified a Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 DNo 14. Race - American Indian, 12. 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married 1 ☐ Yes 2 12 No 21215-0036 ö If Yes, Give Year or Dates þ 3 Widowed 4 Divorced "natural", al Hygiene. J other than "natura event, the Medical F Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be and Mental marked ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship 9 t of Health a Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation moval from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature Part. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock one art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate vause (Final disease or condition resulting in death) **Physician** /Medical Due to (or an a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ed by the attended for t in the past 12 months?

1 Yes 2 No
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9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 26. Place of Death Check only one completely filled in by the funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No 1 Apatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ after death.

Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural 5 Pendina 1 Yes 2 No investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined 4 Homicide within 24 hours a
To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Matthei

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 0 2 2010

32. Registrar's lignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:22 P M 2010 28 Thomas May Rowena Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Corroll County Hospice Dove House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 1 □ M 2 🔀 F Months Hours Min. Director Feb. Texas 455-24-5933 Usual Residence of Deceden show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No New Windsor Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21776 2301 Bowersox Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. White 3 🖵 Widowed 4 🗌 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Acme Supermarkets Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeddie Downey ပ္ Vivian Myrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 Bowersox Rd. New Windsor, MD 21776 Donna Rawlings-daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth XX Burial 2 Cremation 3 Removal from State June 10,2010 Owings Mills MD 4 Donation 5 Other (Specify) Garrison Forrest 22. Name and Address of Facility Ambrose Funeral Home Inc. of Funeral Service Licensee 1328 Sulphur Spring Road MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ End to (or as a conseq rince of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
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Il Director: Aff 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29c. License number

State Registrar

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32. Registrar's Signature

Kord Caturille mo 21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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Ω	To the Hospital or within 24 hours afte To the Funeral Dir completed filled in	ical	29a. Certifier 1 Certifying Phy	sician: To the best of	my know	ledge, death	occured at the	time, date an	d place, an	d due to the ca	iuse(s) ar	nd manner as	stated.		_
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			> Michael 2	fauder n	.1.91.		<u> </u>	(ES-0	00		MA	Y 31,	20	010	_
	n		30. Name and address of person who					مطرا	0	m	4	10 0	224		
			MICHAEL SAUDER 31. Date filed (Month, Day, Year)	M.D. 4	940 ari Signa	EASTER	N AVE	VUE	BAL	TIMORE	Įv.	10 21	217	_	-
	Stat Registra		JUN	2 2010	Dener	u B	par								

Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s after death.

I Director: Af
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10a. State

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Completed

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Physician/

Medical

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Ph sician/ Medical

Baltimore, Maryland 21215-0036

111	disease or condition resulting in death)	_ COMC	OBSTUC	we rumon	acy vised	se i	years
		Due to (or as a consequ	ence of):	we rumm rdiomyopa	tu		yans
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ		1.7	J		
cal Exa	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):				
edi		D					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c 9 Unknown	I death 3 - Ectop	ic pregnancy (specify)		23d. Date of de Month	livery Day Year
ed by Pl	Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying	g cause given in Part I.			o the cause of death?
Somplet					24a. Was an autopsy performed?	prior to death?	ntopsy findings available completion of cause of
Be (25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)		30 70
	1 ☐ Yes 2 🛣No	ospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other:	lome 5 X Residence	6 Other (Spec	cify)
Medical Certificate: To	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how inj		
Certil	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		ory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)		
Medica	(Check 2 Medical Examination	cian: To the best of my knowler: On the basis of examination Practioner: To the best of my	and/or investigation,	in my opinion, death occurred	at the time, date and pla	ce, and due to the	cause(s) and manner stated
	29b. Signature and title of certified	POUS MA	2	9c. License number		Date signed (Mont	

Elhan MD 21921.

State Registrar strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month James Miles Ussery 5:52 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore HOSOITA N/A 5. Social Security Humber If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1919 1**火** M 2□ F Maryland 572-03-7491 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar mast be purified an once. 10c. City, Town or Location 10d. Inside City Limits X□Yes 2□No Director N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2219 Wilkens Avenue 21223 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Stee1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert L. Ussery Cora B. Floyd ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Stouffer - Niece 5807 Harman Avenue, Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State oudon Park Cemetery 6-1-2010 Baltimore, MD 4 □ Dopation 5 □ Other (Specify) Funeral Service 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road, Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician Acute disease or condition resulting in death) DGYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): the attending physician hed for use as the burial IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3
 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification pletely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number MYD MGY, 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSKURAV 3455 Ba Himore, MD Deenak Wilkens

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vrablic, Jr. Raymond Physician/ Month May $20\overset{\text{Year}}{10}$ 7:25P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1925 Codd Avenue Dunda1k Baltimore Co. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year, 1 🔯 M 2 🗆 F Director 56 216-62-9388 Feb 1954 Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminar must be actived. 10a. State 10d. Inside City Limits 10c. City. Town or Location Director Dunda1k 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b Completed by Funeral United States 21222 1925 Codd Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Local 16 Iron Worker 12 Years 6 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gloria Helen Duff Raymond Ignatius Vrablic, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Cigar Loop Havre De Grace, MD 21078 312 Cigar Loop Wendy Laveroni (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 6/7/2010 Towson, Maryland Hilltop Service Corp. Signature of Funeral Service Licenses Duda-Ruck Fufferal Home of Dundalk, Inc. Dundalk. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) OCa. Medical Due to (or as a consequence of) Examiner oronal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner signed by the attending physician and deed be detached for use as the burial-transit Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Yes peen 24b. Were autopsy findings available prior to completion of cause of death? . Was an autopsy performed After this certificate has page 2 1 Yes 2 No 2 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 No 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Dath 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident after death Director: / completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year,

strar's Signature

2/236 Michael Martin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\mathbf{P}^{\,\mathsf{M}}$ Mae Valentine May 2010 9:33 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10300 Bird River Road Middle River Baltimore . Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Months Hours Min 1932 West Virginia **Director** 235-48-8745 78 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10300 Bird River Road 21220 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2√12X No Specify: 3 Widowed 4 Divorced Specify. Completed White al Hygiene. d other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirley Edgell Lilly Edgell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ryan (Daughter) 938 A Thompson Blvd., Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State Holly Hill Mem. Gard. 05/29/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signethre of Funeral 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
11 days shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ dise re or condition result g in death) Advanced Small Cell Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this contract of the Funeral Director After this contract of the Funeral Director After this contract. Exami Cause (Disease or linjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death Month ate has been signed by the a page 2 should be detached t g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home SXResidence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) Willian D16801 28May2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month; Day, Year)

William P. McGuire, 9103 Franklin Square Drive, Baltimore, Maryland 21237

Donte Vandiver

10-03949 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 10 1700 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Cen	tificate of De	ath	F	Reg. No.	
Physici		1. Decedent's Name (First, Midd	lle,Last) Antoni				2. Date of Dea Month	ath Day Yea	3. Time of Death
Medical Exami	ner	Donte 4a. Facility Name (if not institution		ndiver y, Town, or Location	May 24, 2	2010 4c. County	0114 hrs		
		Johns Hopkins Hospi		ltimore	TOI Death	4c. County	or Death		
Funeral		5. Social Security Number	6. Sex 7. Ag	st birthday) If U	nder 1 Year If Und	der 24Hrs. 8. Date of Bi	irth (MM/DD/YYY)	9. Birthplace (State or	
Director		213-31-6190	1XM 2F	19	Yrs.	nths Days Hou	rs Min. 09	21 90	Foreign Country) MD
		Usual Residence of Decedent	<u> </u>						
w any		10a. State 10b. County MD Bal	timore	10c. City, 7	Town or Location Randal	letown			10d. Inside City Limits 1 Yes 2 No
Aaryland 28a-f show	tor	10e. Street and Number	.cimore						
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leath v r item	nue	1 X Never Married 2 M	larried Armed Forces				n, Puerto Rican, etc.)		e, etc.
after o	by F	3 Widowed 4 Div	vorced If Yes, Give Year			2 No specify		Specify:	Black
hours	edt	15. Decedent's Education (Spe			16a. Decedent's Usi	ual Occupation (Give	kind of work done T use retired)	16b. Kind of Bu	usiness/Industry
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d with	ĕ	17. Father's Name (First, Middle			- Offer		er's Name (First, Middle,		
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ID 21215-00; should be filed with; and Mental Hygiene, 77 is marked other that	၉	19a. Informant's Name/Relations	ship (Type, Print)			ess (Street and Nu	mber or Rural Route Nu		
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Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Oppartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once		1 X Burial 2 Cremation	n 3 Removal from Sta	ate cr	lace of Disposition (I ematory or other pla		Date		- City or Town, State
Baltimor permit. Pages Department of Important: If injury or othe		Donation 5 Other S, 2 Signature of Funeral Service		Mt	. Zion	1411 45 10	5/28/2010	Balt:	imore, Md
Balti permit. Departm Imports injury o		2 Signature of Puneral Service	BKLK	e .		nd Address of Facili PARA SA	st Ave, Balt	imore.	Md 21215
Physician		23a Part I. Enter the disease, or	complications that caused	the death. I	Do not enter the mod	de of dying, such as	cardiac or respiratory an	rest, shock, or hea	art Approximate Interval Between Onset and
. ∕Medical ≟xaminer		Immediate Cause (Final disease a. Multiple Gunshot Wounds							
		or condition resulting in death)	Due to (or as a conse	equence of):		- -			
	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):	<u>. </u>			-	
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79. nuted rransit		events resulting in death) cast	d	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
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the ph	-	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcome	ne of pregna				23d. Date of	
Box 687 death certificate attending	ciar	past 12 months?	1 Live birth 4 Pregnant at	time of deat	2 Fetal dea		ic pregnancy	Month	Day Year
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OFC law rehas be	eld (24a. Was	osy p	Were autopsy findings available orior to completion of cause of death?
tal Rec	Completed						1 Yes		Yes 2 No
'ital Sician Is certi	a	25. Was case referred to medica examiner?	(Hospita):	nt 2 🖋 🗉	R/Outpatient 3	26.Place of Death		Residence 6	Other:
of Ving Physi ang Physi After this	٦.	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Inju	rv I	28b. Time of Injury	28c. Injury at World		how injury occurre	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should the fineral director.	Ęį	1 Natural 5 Pend		ear)	0043 hrs	1 Yes 2 ✓	Subject sho	ot	
IVISIOI or Atten after death Director:	ifi		d not be 28e. Place of In	ury - At hon	ne, farm, street, facto	ory, office building, e			er or Rural Route Number, City
Di spital	Certification:	4 Homicide	rmined (Specify) Sid	ewalk			or Town, S 900 N. Belnor	rd Avenue, Balt	timore, MD
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page			hysician: To the best of my miner:On the basis of exar						
To t with Com	Medical	29b. Signature and title of certific	and manner stated.			29c. License number			ed (Month, Day, Year)
		1115	11 -		7	O.C.M.E.	OCME	May 24, 20	, , , ,
- n		30. Name and address of person	who completed, use of d	eath (Item 2	(3a)				
d	1	Theodore M. King, Jr.	41		•	Penn Street, Ba	altimore, MD 2120	1	l
St Regist		31. Date filed (Month, Day, Year)	32. Registra	's Signature	A. bar	11			

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 **Physician** 2010 8:15a anme: eanet /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare of Severna Park <u>Severna Park</u> Anne Arundel 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F 220-28-7700 Director 78 Aug. 8, 1931 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral <u>244 Sheila K Ct.</u> 21144 United States
14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify. 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 LPN Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Carroll Armstrong Nora Grace Burgman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 244 Sheila K. Ct. <u> Virginia Shupe-Campion /Sister</u> Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5/27/2010 Crematory Catonsville, Maryland 21. Signature of Funeral Set 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. ice Liger 11013 421 Crain Hwy. SE Glen Burnie, MD 21061 23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eumon disease or condition resulting in death) /Medical Wie to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 mop 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 atural 5 ☐ Pending investigation 1 Tes 2 No 2 ☐ Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined within 24 hours a Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature an ans Huy Millersville MU21108 ed cause of death (Item 23a) (Type, Print gistrar's Signature Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MESTIN MARY Month Year MA-:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death re-Kandallstown Itimore 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Min. Director Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore UVND 10e. Street and Numbe 10g. Citizen of What Country? Funeral Brompton 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Vaughter uynn Oak, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, Method of Disposition Date Burial 2 Cremation 3 Removal from State PKG-4-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4611 Park Heights Ave Himore, MD 21215 Jones 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA STAGE disease or condition resulting in death) ENO Y EARS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} \) ၉ 2 🗖 No Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) K.S. RAO- 57.0 JUNE 01, 2010 043462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.S.RAO. court 2d 201 # 019 12 condall stow 31. Date filed (Month, Day, Year) State Registrar

NHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:27 AM Ma Dara 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAltimore Washington ANNE Alunde Medical Center G 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🙀 F Months Days Hours Min. 07-07-1932 timore,MD 215-28-0144 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 21 is marked to ther than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Baltimore MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S. 21226 1335 Hazel Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11 Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Tes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Homemaker 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Henry Campbell Hazel Lee Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21225 Barbara A. Holly 635 Cheraton Rd. / Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 106-02-201**0** 4 Donation 5 Other (Specify) Cedar Hill Cem. Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murray & Tellington Funeral Home/4804 Georgia Ave, NW/Wash., DC 20011 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of Examiner oration VISCUS Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Du to (or s a conse uence of) nolecystitis attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor 1 🗆 Yes 2 🗆 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မ 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 68240 who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10e per Fh G904 6/2/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** N. Migne Mistine 11:26 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Body, 9. Birthplace (State or Foreign Country) yn wrong 7. Age (In yrs. last birthday) Noopilal If Under 2 8. Date of Birth (Month, Day, Security Number If Unde **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 7-38-0694 Director Usual Residence of Decedent 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examiner must be retitled at once. Director 1 Yes 2 No more 8408 Carlson Lane 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify 2 3 M Widowed 4 □ Divorced lac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 2 homas Jamin 19a Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9300 arsinsKun assanara MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State -2010 4 Donation 5 Dother (Specify) Signature of Funeral Service Licenses 2. Name and Address of Facility aughn C. Greene Funeral Services Randallstown, MD 21133 oacl Vauc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a cont equence of): disease or condition /Medical resulting in death) Examiner استدان Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): signed by the attending physician and I be detached for use as the burial-tran resulting in death) Last Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Ye ar 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ s peen si 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy After this certificate Division of Vital 1 ☐ Yes 2. No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 28th 00056632 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21133 Pay, Year) 32. Reg State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5,20b,c,perFH,G904,6/22/2010,WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1.-Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ 28 ven 2010 PM 25 lene Medical n, give street and number) 4c. County of Death 4a. Facility Name (if not institution 4b. City, Town, or Location of Death **Examiner** timore mo 8. Date of Birth (Month Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) last birthday) 220al 2221171131 Age (In yrs **Funeral** 1 M 2 P Months Hours Min Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notime." 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 ► No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral USA 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Mever Married 2 ☐ Married ģ 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b, Kind of Business Industry ife. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Martin Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ lar)wens Warren CIE OC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glene 703 ames cemetery, crematory or other place) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City WoodLawn, Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 7-2010 4 Donation 5 Other (Specify) Woodlawn Cemetery 22. Name and Address of Facility Signature of Funeral Service License Funeral Skrvices 2/133 au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Prevmonio disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of; the Hospital or Attending Physician: The law requires that the death certificate be executed and -trans Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year been signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed To the Funeral Director After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie AT2438941 05/28/2010 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) HUSDITCH Paltimore MI menono 3000 32. Regis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 29 3:00 AM Williams May Jesse Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Year) - 1<u>923</u> 1.₩M 2 🗆 F Months Days (Month, Day, Feb 12 87 Maryland **Director** 245-42-1380 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 United States 2840 West Garrison Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗃 No "natural" 35 Widowed 4 Divorced Completed Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Bricklayer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be traumatic Arthur Williams Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Brenda Williams /Daughter 2840 West garrison Avenue Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jun 02 Burial 2 Cremation 3 🗆 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 22. Name and Address of Facility

Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee M01442 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) HUPERCARAL Medical the to (or as a consequence of) Examiner ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine as the burial-transit EMPHUSEMA that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month detached 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ VASCULAR DEMENTIA Records, Completed 2 No 3 Probably 4 Unknown peen CORUNARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? PERIPHERAL VASCULAR NISPASS this certificate 1 Yes 2 No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o ٥ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division ☐ Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

2+1

State Registrar DANIEUE

31. Date filed (Month, Day, Year) JUN 0 2 2010

DHMH 17 Rev 7/2009

6701

N CHAPLES ST, 8417, 405 BACTMONE, ALD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 4:50 4M Sister Leona Williams 2010 Mary 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltmore altimore orthpoint uture Care 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex (In vrs. last birthday) **Funeral** Months 1 □ M 2 X F 533-14-0343 Director 88 03 18 TXUsual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 ☐ No Catonsville Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 701 Gun Road 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Never Married 2☐ Married Maryland 21215-0036 1 ☐Yes 2 🔀 No Specify 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2th grade School 3yrs Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be or other traumatic ပ Claude Russell Williams Obelia Hudson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any injury or other trau Sister Clarice Proctor Gun Road, Catonsville, Md 21228 <u>701</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/3/2010 Loudon Park Baltimore, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March F/H West 4300 Wabash Ave, n Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 day rena acute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit certificate be execut attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy õ in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Coronary Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a Was an myo Cardia autopsy performed? 1 Yes 2 Who r this certificate h rat director, page disease diabetes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Vitin 24 hours after deau.

To the Funeral Director: After this c 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physicians. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marine as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saltimore, MD Holden laia 31. Date filed (Month, Day, Year) 32. Regist ar's Signatur State 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 0 7073

		1- For State Registrar	Certif	icate of	Death		Reg	No	
Physici ledical Exami		Decedent's Name (First, Middle, Last) Viola Withe	rspoon				2. Date of Death Month May 24, 20	Day Year	3. Time of Death 1252 hrs
)		4a. Facility Name (if not institution, give str		4	b. City, Town, c	or Location of Deat		4c. County of	
. <i>'</i>		422 Normandy Avenue	17.00		Baltimore	Tru i ou	To Day to the	N/A	
Funeral Director		5. Social Security Number 212-22-0323 6. Sex	7. Age (In yrs. last)	Yrs.	If Under 1 Ye Months Da		_		9. Birthplace (State or Foreign C ∰rttry)
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To				_		10d. Inside City Limits
* *	or	MD N/A	Ba	ltimo	re				1 X Yes 2 No
the Maryl Sa or 28a-l	Director	10e. Street and Number 422 Normandy Av	enue		10f. Zip Code 212	229	100	g. Citizen of Wha	t Country?
215-0036 The filed within 72 hours after death with the Maryland hall Hygienen han "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married 1	Was Decedent Ever in U.S. Armed Forces? Yes 2 X No	If Ye	s, specify Cuba	ispanic Origin? (S an, Mexican, Puert		White,	
urs afte tural", aminer	þ	3 XWidowed 4 Divorced If Y or 15. Decedent's Education (Specify only h	Jates.		Yes 2 X N	o specify: ation (Give kind of	work done	Specify:B	
36 hin 72 hou e than "na edical Exi	leted	Elementary/Secondary (0-12)	College (1-4 or 5+)	_		e. DO NOT use re			,
5-003 led within Hygiene other the	Comple	9th 17. Father's Name (First, Middle, Last)	N/A	Nurse	s Aide		e (First, Middle, Ma	Nursin	g Home
21215-00 uld be filed wii Mental Hygien marked other c event, the M	Be C	James Allen					e McLai	,	
D 21 should and Me	7	19a Informant's Name/Relationship (Type, Agnes Russell/S	Print) ister	19b. Mailing 4 2 0 N	Address (Stre	et and Number or Ay Ave.	Rural Route Numb	er, City or Town, ore, M	State, Zip Code) D 21229
Ore, es l and of Heal If item		20a. Method of Disposition 1 XBurial 2 Cremation 3 1	Removal from State cren	natory or othe	ion (Name of ce er place) n Cem	· ·		20c. Location - 0 Lansdov	City or Town, State
Baltim permit Pag Department Important:	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	No. 1.E	22. Na	me and Addres	ss of Facility Be	verly D	. Croma	artie F/S
Physician	11 14	23a. Part I. Enter the disease, or complicat							
Examiner			_{ne.} Pertensive Atherosclero	otic Cardio	vascular Di	sease			Between Onset and Death
d		h	to (or as a consequence of):						
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
recuted		(Disease or injury that initiated events resulting in death) Last Due d.	to (or as a consequence of):						
ज्ञ ड	Medical	UNPENDED A	MENDED						
8760, ificate be ig physici		23b. Was decedent pregnant in the	Bc. If yes, outcome of pregnand Live birth		Il death 3	Ectopic pregn	ancv	23d. Date of d	elivery Day Year
P.O. Box 68. That the death certifine ned by the attending detached for use as I	Physician	past 12 months? 1	Pregnant at time of death	_	er (Specify)			WORKI	Day Teal
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by timeral director, page 2 should be detach.	by P	Part II. Other significant conditions con	tributing to death but not result	ting in the un	derlying cause	given in Part I.			ute to the cause of death?
× 50 5	ted						24a. Was an		Probably 4 Unknown ere autopsy findings available
COLO	Completed			. <u> </u>			autopsy perform	pri	or to completion of cause of ath?
n: The rifficate or, pag	င်	25. Was case referred to medical			26.Plac	e of Death (Check	only one)	✓ No 1	Yes 2 No
Vita hysicia this cel	To B	examiner? 1 ✓ Yes 2 No	tal: 1 Inpatient 2 ER	/Outpatient		Other:		esidence 6 🗸	Other: Scene
		1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	b. Time of Inj		ury at Work? Yes 2 No	28d. Describe ho	w injury occurred	i
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home.	, farm, street	factory, office	building, etc.	28f. Location (Str or Town, Sta		or Rural Route Number, City
Hospits 24 hours Funera		4 Homicide	(Specify) To the best of my knowledge, of	death occurre	ed at the time, d	late and place, and	due to the cause(s) and manner a	s stated
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On and	the basis of examination and/o manner stated.	or investigation	n, in my opinio	n, death occurred	at the time, date ar	d place, and due	e to the cause(s)
	Σ	29b. Signature and title of certifier	/	1	29c. Licen: O.C.			29d, Date signed May 25, 201	(Month, Day, Year)
h./		30. Name and address of person who comp	teted cause of death (Item 23:					ay 20, 201	~
3√			t Medical Examiner		Street, Bal	timore, MD 21	201		
St Regist	_	31. Date filed (Month, Day, Year) 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	32. Registrar's Signature	1. 60	and I				,

10-04025 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Madison Kasey Whitley 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month 1421 hrs Medical Examiner May 26, 2010 Madison Kasey Whitley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Johns Hopkins Bayview Medical Center If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Min Country) 217-85-4935 Days Hours Director MD М 2 X F 8-4-2009 Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location ģ 10a. State 10b. County 1 X X Yes 2 No MD Baltimore 28a-f show na Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 7936 Gough Street Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Yes 2 x No Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: ð 16b. Kind of Business/Industry na 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) na Elementary/Secondary (0-12) College (1-4 or 5+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Steven Whitley Dominic Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21224 Steven Whitley-Father 7936 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King Memorial Pk 6-2-2010 Randallstown, 4 Donation 5 Other Specify.

21. Signature of Funeral Service Licen March East F/H 22. Name and Address of Facility Balto, MD 21202 1101 E. North Avenue Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter **Physician** Between Onset and failure. List only one cause on each line Avicalua Death Complications of Congenital Heart Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical AMENDED 23a,27 per me $g906 8\overline{-17-10}$ vt X UNPENDED attending physician for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed has been si 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' this certificate page ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural 1 Yes 2 No Pending 24 hours after death. Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 27, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eleanora Wells May 2010 26 1:30 рм Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Martin's Home Baltimore Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral 1 M 2 XF Months Days Hours 0272071919 Maryland 91 213-34-6078 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Catonsville 1 Yes 2 X No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ıral", or items 23a o Examiner must be Funeral 601 Maiden Choice Lane 21228 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Divorced 4 Divorced Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Catholic Church <u>Secretary</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 and 2 should be Health and Ments 27 is marked traumatic e Harry Wells Myrtle Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9702 Liberty Road, Baltimore, Maryland 21133 Yvette A. Carter (Goddaughter) item 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2 【**Cremation 3 ☐ Removal from State Bayview Crematory 06/04/2010 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Si nat re of Funeral Service Licensee Hubbard Funeral Home Avenue, Baltimore, Maryland 21229 4107 Wilkens 23a. Part 1- Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Securifiely list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Day Month Year Pregnant at time of death signed by the a 1 ☐ Yes ≥ ∞ 9 ☐ Unknown 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2, No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 si autopsy performed2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural work' 1 🗌 Yes Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 021649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANBANDAM BASKALW 3455 WL Wilkens AVR. Baltimori BASKER 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

			Amend #8 per Fh	BJAbe 12/Lintin	Black Indelible Inl	k. Ensure Al	l Copies A	re Legible.	
		-	For State Registrar	State of Marylan	o / Department of F Certificate of L		entai mygier _{Reg. I}	-211111	17076
	Physicia		1. Decedent's Name (First, Middle,	le hh			2. Date of Death Month	Year Year	3. Time of Death 10:40 AM
	Medic Examin		4a, Facility Name (if not institution of	. 1	4b. City Town, o	r Location of Death		4c. County of Deat	h
	Funeral			! NTEY . Sex 1 □ M 2 X F 7. Age (In yrs. Is	1/ Vro Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month/Day, Year		hplace (State or Foreign untry)
	Director	L	Usual Residence of Decedent 10a. State 10b. County		y, Town or Location		2 18 +	<i>G</i>	10d. Inside City Limits
	Marylan 28a-f sh otified a	Director	Md Rattin	ore Col	Keysville				1 🗆 Yes 2 🔀 No
	with the s 23a or ust be n	Funeral D	10e Street and Number 512 Lake Vista	Circle Apt. J	10f. Zip Code	30	10g.	Citizen of What Co	untry?
036	should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ed by Fun	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	an, Mexican, Puerto F	ify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	72 hour in "natu Medical	Completed by	15. Decedent (Specify only highest	grade completed)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	during most of workin	g 16b	. Kind of Business	Industry
3 212	ed withir Hygiene Ither tha	Be Co	Elementary/Seconday (0-12) 17. Father's Name (First, Middle, La.	College (1-4 or 5+)	Laborer	18 Mother's Name	(First, Middle, Maide	OUSEKeep on Surname)	119
Maryland	ild be file Mental I narked o natic eve	To I	Frank Web	b		Edi	na Ban	KS	
_	○ = % T		19a. Informant's Name/Relationship Debovah Henson	Daughter	19b. Mailing Address (Street 512) Lake Visa	and Number or Rural	Route Number, City Apt J	or Town, State, Zip I CKeYSV//	le, Md 21030
more	age 1 and ant of Hea at: If item y or other		20a. Method of Disposition 1 □ Burial 2 Cremation 3 4 □ Donation 5 □ Other (Sp	B 🗆 Removal from State 🚺 🧿	Place of Disposition (Name of emetery, crematory or other place UNMDUM	ce) 617	ate 20c	Location - City or	Town, State Maxuland
40pm Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signal te of Funeral rvice Lice		22. Name and Addre	ss of Facility	491	5 York X	Cad 217 17
2			23a. Part/1. Enter the disease, or c shock, or heart failure. List on	omplications that caused the deatly one cause on each line.	h. Do not enter the node of dyin	ig, such as cardiac or	respiratory arrest,	(PJ-1MUY X	Approximate Interval Between
	Physician/ Medical	62 6	Immediate Cause (Final disease or condition resulting in death)	a. LUNJ Due to (or as consequ	ANCER Jence of):				Onset and Death
3010	Examiner	ıer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):				
Roh	executed an and rial-transit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	uence of):				
1000		I— I	youting in death, East	d		· · · · · · · · · · · · · · · · · · ·			
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Fete 4 ☐ Pregnant at time of o	al death - 3 🔲 Ectopic pregnan	су		23d. Date of de Month	livery Day Year
120°	s that the gned by be detac	ρ	Part II. Other significant condition	s contributing to death but not res	ulting in the underlying cause gi	ven in Part I.	1.0		the cause of death?
brds,	w requires that so been signed to should be detter	Completed					24a. Was an	24b. Were au	topsy findings available completion of cause of
Bec	sician: The law I certificate has b irector, page 2 s		25. Was case referred to medical		00 0	lace of Death (Check	autopsy performed	? death?	s 2 No
Sita Vita	rding Physician: T th. After this certifica funeral director, p	To Be	examiner? 1 Yes 2 No 27. Manner of Death		ER/Outpatient 3 □ DOA Oth	er: 4 Nursing Hor	ne 5 Residence	7	ity) HOSPICE
ou o	ttending F death. stor, After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investiga	ition	injury work	y at ⟨? Yes 2 □ No	8d. Describe how in	jury occurred	
Division of	al or Atters after de l'Directe		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ome, farm, street, factory, office	2	28f. Location (Street City or Town, Sta		ral Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director, Al completed filled in by the fu	Medical	(Check 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examination durse Practioner: To the best of m	n and/or investigation, in my opini	on, death occurred at	the time, date and pla	ace, and due to the	cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	2000	29c. Licens		29d.	Date signed (Monti	h, Day, Year)
	•		30. Name and address of person w	no completed cause of death (Item		T 61177 1	LINE RAI	TMARE, 1	UN 21204
6	Sta	te	DANIEUR OBES 31. Date filed (Month, Day, Year)	32. Regis rar's Signa	ture	1, ONLIZ 4	IUS OHL	111WEIN	
9	Registr	ar	JUNU	2 2010 Deneva	B. parkel				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ronald Leon White Month 05/23/2010 11:00 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Riderwood Nursing Center Silver Spring Montgomery 7. Age (In yrs. last birthday, 79 Yrs. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **M** M 2 □ F Hours 07/14/1930 Country) Director 163-24-7512 PA Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Silver Spring Montgomery 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3158 Gracefield Rd. 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Yes. Give White 3 Widowed 4 Divorced Specify Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Executive Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clarence William White Grace Elizabeth Gingerich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Monroe Street Ithaca, NY 14850 Erick White- Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/26/2010 Chesapeake Crematory Beltsville, MD Signature Funeral Source Linnse 22. Name and Address of Facility 933 Gist Ave Silver Spring MD Rapp Funeral & Cremation Ser. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death -Physician/ disease or condition resulting in death) Years <u>Malignant Melanoma</u> Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? After this certificate 2 🗌 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 1 Yes 2 No 24 hours after death Funeral Director: Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29d. Date signed (Month, Day, Year) D24093 05/25/2010

State Registrar Rd

Silver Spring MD 20904

Gracefield

giarrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110

32. Regin

Parkhurst

Mark

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 **Physician** 15:48 May 13, Cecelia Joyce Armstrong /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fort Washington Prince George's Fort Washington Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 31, 1955 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 54 DC 577-80-1672 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r 28a-f sh notified 1 X Yes 2 ☐ No Director Prince George's Oxon Hill Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 20745 7300 Dominion Drive United States Funeral ural", or Items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 1 No African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced American 'natural", Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Custodian 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn M. Biscoe John R. Armstrong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7300 Dominion Drive Oxon Hill, Md. Evelyn Armstrong/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Saint Peter's Clavers 1 Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 2010 Saint Ingoes, Maryland Church Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. of Funeral Service Lices 4001 Benning Rd. NE Washington, DC 20019 Approximate 347
Interval Between Opset and Death 23a. Part heter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock the heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant 3 Ectopic pregnancy in the past 12 morths? 1 ☐ Yes 2 ☑ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) ed by the a 9∏Unknown 9 Unknown signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part* 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? Yes 2 100 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 PER/Outpatient 1 Inpatient 3 DOA Certification: To this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Hospital or Attending 1 WNatural 5 Pending investigation n 24 hours after death.

e Funeral Director: A
bletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of parent for completed cause of death (Item 23a) (Type, Print) Shantha Murthy, MD 6196 Oxon Hill Road Oxon Hill, Maryland 20745 31. Date filed (Month, Day, Year) 32. Registrar's Signar State MAY 182010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Stanley Η. Armstrong 7:20 PM 2010 Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign . Age (In vrs. last birthday 8. Date of Birth **Funeral** Months 1 🗓 M 2 🗆 F (Month, Day, Year), 12/30/1940 69 Washington, DC Director 579-50-5608 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d, Inside City Limits Director District Heights MD Prince George's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 US 6903 Landsdale Street permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: among an injury or other traumatic event, the Medical Examiner must once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DC Dept. of Public Elementary/Seconday (0-12) College (1-4 or 5+) 11 Works Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Martha Paradise Stanley Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) District Heights, MD Martha Armstrong / Wife 6903 Landsdale St. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 5/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Servi 22. Name and Address of Facility Fort Lincoln Funeral Home nsee 20722 3401 Bladensburg Rd. Brentwood, MD 23a. Part 1. Enter the disease, shock, or heart failure. Lis fr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ LOLO disease or condition resulting in death) COL Medical Due to (or as a consuluence of). **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by non STelevation Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown (3-4 clisc humalur 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? neumonica has autopsy performed? Colliver Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifie

of person who completed cause of death (Item 23a) (Type, Print

29d. Date signed (Month, Day, Year)

0.5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 11, 2010 21:03 Alice W. Aslam Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 947 1 🗆 M 2 🔼 F Months Days Hours April 2. DC. 577-66-7036 Director 63 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Landover Hills Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3984 Warner Ave. # B2 20784 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give **Black** 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) DOT Clerk Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Ray, Sr. Alice Green Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Wells/ Daughter 3984 Warner Ave. #B2 Landover Hills, Md. 20784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 18, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Lee's Crematory 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Sonature of Funeral Service 2. Name and Address of Facility Stewart Funeral Home, 4001 Benning Rd. NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Pancreatic Carcinoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed Disheles 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate has page 2 Fibromyalgia 1 Yes 2 No 25. Was case referred to mical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending work?
1 Yes 2 No 2 Accident Investigation 124 hours after deat e Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the P only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) MAY D40324 12,2010

State Registrar 7600 CARROLL AVENUE, TAKOMA PARK, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

TERRY JODRIE, MD, FACEP

d (Month, Day, Year) MAY 1 8 2010 State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	,	Cer	tificate of l	Death		Reg. No.		
Physician/ Medical			Decedent's Name (First, Middle, Las: HERM				2. Date of Dea Month May		3. Time of Death 10:47A ^M		
Examiner			4a. Facility Name (if not institution, give s Prince George's	er	4b. City, Town, o Chever]	r Location of Death Ly	1	4c. County of De Prince (George's		
	Funeral Director		5. Social Security Number 578–68–2356 6. Se Usual Residence of Decedent	x 31 M 2 □ F 7. Age (In yrs. Ia 58		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Jun . 11	v, Year) C	irthplace (State or Foreign ountry) Shington, DC	
	Maryland Ba-f show tiffied at	Director	10a. State 10b. County	George's	Town or Loc Springe	ation lale	•	_		10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	s 23a or 2 nust be no	Funeral Di	10e. Street and Number 4004 91st Ave	nue		10f. Zip Code 2077	74		10g. Citizen of What C		
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.	ڇ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	lf	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: B1a	ite. etc.	
Baltimore, Maryland 21215-0036	vithin 72 hor iene. r than "nat the Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give k life. DC	ent's Usual Occup ind of work done o O NOT use retired) Electrici	during most of wor	king	16b. Kind of Business Govern		
land 2	d be filed w Aental Hyg Irked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Nelson Samu	el Able, Jr.			18. Mother's Nan Beatr		Maiden Surnarne) Kiser		
, Mary	nd 2 should ealth and N n 27 is ma		19a. Informant's Name/Relationship (Ty) Diane Claybrooks-		19b. Mailin 400		Avenue, S		r, City or Town, State, Z 1e,MD 20	ip Code) 774	
timore	Page 1 al tment of H tant: If iter jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	metery, crem mony M		ark 05/2		20c. Location - City of Hyattsvil	lle, MD	
Ball	permit Depar Impor any in once.		21. Signature of Funeral Service Life ise	e //	22.	Name and Addres 4001 Benr	ss of Facility Jo ning Rd.,	rdan Fur N.E., Wa	neral Servi ashington,	ce, Inc. DC 20019	
\}	Medical Examiner	resulting in death) a. Due to (or as a consequence of):									
8760	tificate be executed ng physician and s as the burial-transit	Medical Examiner	if any, leading to immediate cause. Chief Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence)							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certific, within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnance Other (specify)	;y		23d. Date of de Month	elivery Day Year	
ds, P.O	quires that t en signed b ruld be deta		Part II. Other significant conditions con	ntributing to death but not resu	Ilting in the ur	nderlying cause giv	ven in Part I.		obacco use contribute t ∕es 2 □ No 3 □ f	o the cause of death? Probably 4 🕅 Unknown	
Records, P.O.	The law recate has be page 2 sho	Completed by						24a. Was a autop perfor 1 Yes	rmed? prior to death?	utopsy findings available completion of cause of es 2 No	
ta .	ician; certific ector,	Be	25. Was case referred to medical examiner?	lospital:		Othe	ace of Death (Chec	k only one)			
Division of Vital	nding Phys tth. : After this e funeral dir	cate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 ✓ Inpatient 2 L E	R/Outpatient 28b. Time of injury	28c. Injury work	4 ∐ Nursing H ⁄ at		ence 6 Other (Spe	cify)	
Divisio	tal or Atter s after des al Director ed in by the	Il Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	1		28f. Location (Si City or Town	(Street and Number or Rural Route Number, own, State)		
	the Hospi hin 24 hou the Funer npleted fill	Medical	(Check 2 Medical Examin only one) 3 Certifying Nurse	cian: To the best of my knowle er: On the basis of examination Practioner: To the best of my	and/or investig	gation, in my opinic	n, death occurred a	t the time, date ar	nd place, and due to the	cause(s) and manner stated.	
	8 2 kg 2		29b. Signature and title at certifier	up		29c. License		1	29d. Date signed (Mont		
	4.1		30. Name and address of person who co	4n 3001 1	HOSDI,	tal Di	K Che	verly	inp 2	00785	
	Stat Registra	e	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ne /			/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jose Roberto-Ru		Argueta Š 1- For State Registrar	tate of Maryla	•	ertment of tificate of		nd Me	ntal Hy		eg. No. 20	10 17082
Physicia Medical Examir	n/	1. Decedent's Name (First, Midd	e,Last) o Rubi Arqueta						2. Date of Death Month May 11, 20	h Day Year	3. Time of Death 1824 hrs
)		4a. Facility Name (if not instituti	on, give street and nur		4	1b. City, Town,	or Location	n of Death	ividy 11, 20	4c. County of I	
Funeral		Montgomery General 5. Social Security Number		7. Age (In yrs. la	ast birthday)	Olney If Under 1 Y	ear If Un	der 24Hrs.	8. Date of Birt	Montgome	9. Birthplace (State or Foreign
Director		None	1XM 2_F	33	Yrs.	Months Da			01/20		Country) Honduras
À		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Locati	00					10d. Inside City Limits
id how any					Silver S						1 XYes 2 No
Maryland 28a-f show	Director	10e. Street and Number	cgomery		ottaer '	10f. Zip Code			10	g. Citizen of What	: Country?
ith the Maryland 23a or 28a-f sho notified at once.	희	11912 Lafaye				209				Hondur	
eath wit items	Funeral	11. Marital Status 1 Never Married 2 N	Married Armed Fo			s Decedent of I es, specify Cub			ecify Yes or No- Rican, etc.)	14. Race - / White, e	American Indian, Black, etc.
after de al", or iner mi	by Fu		or Dates:		1 🔀	Yes 2 1	No specif	y: Hono	durian	Specify: I	Hispanic
hours natur	eted t	15. Decedent's Education (Spi Elementary/Secondary (0-12				t's Usual Occup ost of working li				16b. Kind of Busir	ness/Industry
036 ithin 72 ne. r than	Comple	12th	College (1	4013.)	Labo	or				Const	ruction
21215-0036 Auld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle						·		Maiden Surname)	
212. uld be Mental marke	To Be	Victor Manuel 19a. Informant's Name/Relation		1	19b. Mailing	Address (Str			rgueta ural Route Num	ber, City or Town,	State, Zip Code)
MD d 2 sho lith and n 27 is	-1	Darling Aracely	Rubi/Sist					Drive			, Md. 20902
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 R Burial 2 Cremation	n 3 Removal fro		Place of Disposi rematory or oth	er place)	•		Date	20c. Location - Ci	
Iltim nit. Pag artment sortant:	1	4 Donation 5 Other S		1	General				/21/10 n.T. Rh	Hondu	eral Home
Dep Den Ba			Lucis	Sile	X 1 30	005 12t	h. St	. NE	Wash. D	o.c. 2001	.7
Physician in the second		23a. Part I. Enter the disease, o failure. List only one cause	on each line.		Do net enter th	e mode of dyin	g, such as	cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		e s consequence of):						
	P.	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence of):						
0	Examiner	cause. Enter Underlying Cause (Disease or injury that Linuated events resulting in death) Last	C	consequence of):						
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60, te be execut ysician and burial - tra	ledical	UNPENDED	AMENDED		22d Date of deliver						
tox 68760 eath certificate be attending physi for use as the bu	an/M	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	he 1 Live bi		2 Fet	al death 3	BEctop	ic pregnan	су	23d. Date of de Month	Day Year
Box e death o the atten	Physician/M	1 Yes 2 No 9 Ur		ant at time of dea wn	ath 5 Oth	ner (Specify)					
P.O. B es that the disiple by the be detached	by Pr	Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	nderlying cause	e given in F	Part I.			ite to the cause of death?
ords, P.C. w requires that is been signed should be deta									1 Yes		Probably 4 Unknown
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tal Rec	မိုင်	25. Was case referred to medical	al			26.Pla	ce of Deat	n (Check or	1 Yes 2	2 No 1	Yes 2 No
Vital Physician: r this certifi	0	examiner? 1 Yes 2 No		patient 2			Other ₄				Other:
Division of Vital Records, tal or Attending Physician: The law requirns after death. Tal Director: After this certificate has been sited in by the funeral director, page 2 should be a should by the funeral director, page 2 should be a should be	힐	27. Manner of Death 1 Natural 5 Pen	28a. Date of May 11, 2	Day Year) 2010	28b. Time of Ir 1725 hrs	· ·	juryatWo]Yes 2 🔽	_ lo		ow injury occurred an auto to fix	ked object collision
Division pital or Attent ours after death teral Director: filled in by the	Certification:		stigation 28e. Place	of Injury - At ho	me, farm, stree	t, factory, office	building,	etc. 2	28f. Location (Si		or Rural Route Number, City
Dj Hospital o 24 hours a Funeral I		4 Homicide dete		Local Stree				- 1	eorgia Avenu	ue át Gregg Road	d, Silver Spring , MD
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	edical	(Check only Certifying F	hysician: To the best irniner:On the basis o and manner st	f examination an							
29d. Date signed (Mc											
7		Hameh Southan	11. m).			0.0	C.M.E.			May 12, 2010)
		30. Name and address of person Pamela E. Southall, N		e of death (Item: Medical Exar		l Penn Stre	et, Baltii	more, Mi	D 21201		
Sta	ate	31. Date filed (Month, Day, Year)	2010 32 Reg	gistrar's Signatur	bar						
Registi	ar	nut - t	Len	un p.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Barnes Physician/ Shirley Month ZOIC Mas Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Manyland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Apr 12, 1935 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Min. Hours Mary land 75 Director 213-34-2681 Apr Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Westminster 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1415 Brown Road 21158 USA 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Marshall Van Horne Helen Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Brown Road, Westminster, Charles E. Barnes, husband MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Burial 2 Cremation 3 Removal from State any injury or Evergreen Memorial Grd Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 5 days Preumonia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hypertension ge Pulmonary 2 No Records, 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Renal failure page 2 s autopsy performed? Yes 2 No 1 Yes 2 No ever fai of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ this Certificate: 27. Manyer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun Natural 5 Pending Division Investigation 1 Yes 2 🗌 No Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number P24445 29d. Date signed (Month, Day, Year) WJL 1346475191 14, 2010 MD

3 State 30. Name and address of person who completed cause

Goldberg

Sarah

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Greene Street Baltomore, MD ZIZOI

f death (Item 23a) (Type, Print)

South

32. Registrar's Signature

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ Denise Ann Bradford 2010 8:03 AM Medical 4a. Facility Name (if not institution, give street and number)
Southern Maryland Hospital 4b. City, Town, or Location of Death Clinton 4c. County of Death **Examiner** Prince George's 5. Social Security Number 577–76–8493 8. Date of Birth (Month, Day,)

Jan. 19, 7. Age (In yrs. last birthday) 54 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Days Hours Min. Washington DC **Director** 956 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Funeral Director Washington DC 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4471 Ponds St. NE 20019 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 ☐ Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🄀 No Specify: Black Specify: 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PVI. Housekeeping 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Bradford ပ Anna Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Antonia Wilkinson/ Daughter 2405 Southern Ave. #104 Temple Hills, MD 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage Cemetery Waldorf, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Pridgen Funeral Service Lanham, 9013 Annapolis RD MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on ear fline. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Cause (Disease or linjury sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate I 2 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural 1 Yes Investigation 6 Could not be Accident within 24 hours after deat To the Funeral Director; Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one rtifing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29d. Date signed (Month, Day, Year) 055120 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Avenue SE Suite 310 Washington Dc 20032 MI) 31. Date filed (Month, Day, Year) NAY 1 8 2010 32. Registrar's Signatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death P^{M} Margaret Irene Bost 13 2010 915 May 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Berlin Nursing Home Worcester Berlin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days 1 □ M 2 🗓 F 76 Yrs 8/16/1933 TN 314-32-3652 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21811 22 Pintail Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant W.R. Grace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Ochsner Dorothea Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Pintail Dr., Berlin, MD 21811 Richard A. Bost / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 5/14/2010 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signal of Funeral Service Licenses 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebral Hemorrhage Due to (or as a consequence of): mertens ion to (or as a consequence of

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be ပ MD

with the Maryland

death

filed within 72 hours after

Health and Mental Hygiem 27 is marked other

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I

21215-0036

Maryland

Baltimore,

Margaret

Bost

/Medical

and

attending physician

the

signed by

has

after de th Director:

within 24 ours a

To the Funeral I

BA 6

filled in by

completely

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Examiner

Physician/Medical

2

Completed

Be

Medical Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant In the past 12 months?

1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

9 Unknown

Due to (or as a consequence of)

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown

Vear

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.

Yarkinson Colon Cancer

24a. Was an performe yes 2 1 ☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

Hospital:

28b. Time of 28c. Injury at Work? 1 □Yes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a, Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H 00 700 20

29c. License number

05-14-2010

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Diane Ceruzzi, DO 9715 Healthway DR, Berlin, MD 21811

State Registrar 31. Date filed (Month, Day, Year) MAY 17 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 14 Ž&10 MAY **GLADYS** LUCILLE BALDWIN 5:26 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death LARKIN CHASE NURSING HOME BOWIE PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. (Month, Day Ye "1928 NORTH" CAROLINA Director 239-58-2509 81 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. Count permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if frem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 15005 HEALTH CENTER DRIVE 20716 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK If Yes Give 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12TH \end{array}$ College (1-4 or 5+) MACHINE OPERATOR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ JACOB POWELL ETHEL JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY BALDWIN/DAUGHTER CHINABERRY COURT MITCHELLVILLE, MARYLAND 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State WELCHES CREEK CEMETERY5/22/2010 Donation 5 Other (Specify) WHITEVILLE, NORTH CAROLINA Signature of Funeral 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DEMENTIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant g ☐ Unknown g Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy death? 2 X No Yes Hospital or Attending Physician: **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. e Funeral Director: Af bleted filled in by the fu 1 Yes 2 No Investigation Accident Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2. 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the 29d. Date signed (Month. Day, Year) D41978 MAY 14, 2010 18. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12200 ANNAPOLIS ROAD SUITE 228 GLENN DALE, MARYLAND 20769 NADER TAVKOLI M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Yea

32. Registra s Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Brand Day Physician/ Month Year ean 45 M 20/0 Medical 4a. Facility Name (if not institution aive street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Peath Bal 7318 Jakoma al omery Timore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 X X Months Days Hours Min. 1 M907 P9527 MD 220-58-7199 58 Yrs **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Takoma Park 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7318 Baltimore Ave. 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", Specify: White Completed 3XXWidowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Shirley Keegan Duane Charles Brand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 17318 Baltimore Ave. Takoma Park, MD 20912 Department of Health ar Important: If item 27 is any injury or other trau Vanessa L. Penney, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1
Burial 2
Gremation 3
Removal from State cemetery, crematory or other place)
Chesapeake Crematory 5/15/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral 22. Name and Address of FacilityRapp Funeral & Cremation Svcs. M01539 nus 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding hours and action and a second of the second of sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has in by the funeral director, page 2 a autopsy 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 □ No 은 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 4 Nursing Home 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No - SU15 May 13 2010 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Rolle Number, City or Town, State) 7315 3011 2006 28e. Place of Injury - At home, farm, street, factory, office completed filled in by determined building, etc. (Specify) 40me 20917 Long 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) 000428 5010 10 4 mo DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brech Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}201<u>0</u> May Month Physician/ Year Howard Kenneth Brown 13 11:05 P.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 12609 Summerwood Drive Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours July 28 1930 577-38-4914 79 Washington, DC Director Usual Residence of Decedent works 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Marvland Montgomery Silver Spring 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12609 Summerwood Drive 20904 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 1 X Yes 2 □ No If Yes, Give 1954-1958 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: "natural", 3 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) Mental Hygiene. the Sales Xerox item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Howard George Brown Mamie Fdwards .f. Page 1 and 2 shou..

of Health and Mer

or 27 is m? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Brown -wife 12609 Summerwood Drive Silver Spring, Maryland20904 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Lael Church Cemetery 5/19/2010 Lignum, Virginia 21. Signa ur of Funeral Sei Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or ill nury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 2 No the detached 9 Unknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 XResidence 6 Other (Specify) After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide s after death Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) May 14, 2010 D18137 ess of Lyrson who completed cause of death (Item 23a) (Type, Print)
Drobis, M.D. KP 10810 Connecticut Avenue Kensington, Maryland 20895

Registrar DHMH 17 Rev 7/2009

State

Jeffre>

31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) Sept. 08, 1924 If Unde If Under 24 Hrs (In yrs 85 **Funeral** Min 1 🗆 M 2 🗓 F Hours 219-18-3726 **Director** Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Anne Arundel Severna Park MD 1 ☐ Yes 2 🛣 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral **USA** 21146 100 Hilltop Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes : 2 X No Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker/ Banking-Clerk Home/Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Suzanne Whistling James Henry McCulloh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Hilltop Drive Severna Park, MD 21146 Charles L. Brown / Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Crownsville, MD MD Veterans Cemetery 4 Donation 5 Other Specify 2010 Signature of Funeral Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 1. Enter the disease, or co hplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sho k, or heart failure. List only one cause on each line Interval Between Onset an Death Immedia e Cause (Final HE MMORHAGE TRACE Physician/ REBRAI_ disease or condition resulting in death) Medical Due o (or as a consequence of Examine Hypertension sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical CERTIFIC that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) 1 Live Birth
4 Pregnant a
9 Unknown Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to dical Be 26. Place of Death Check only one) examiner?
1 XYes Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manny of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c, License number 30. Nam 31. Date filed (Month,

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State

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 205 tate of Maryland 60 24/2010 and Health and Mental Hygiene (1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Y М DONALD CHARLES BARNES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sep 04,1941 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Hours 218-38-0599 1 🛛 M 2 🗆 F 68 Mary Land **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho Maryland 10b. County Frederick City, Town or Location New Market 10d. Inside City Limits Director 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11102 Eagletrace Drive 21774 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ 1 Yes : 2 **X**No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement Officer Public Safety Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Top Sr permit. Page 1 and 2 should be to Department of Health and Menta Important, If item 27 is marked any injury or other traumatic en Ellis Barnes Pearl В. Hansrode 19a. Informant's Name/Relationship (Type, Print)
Debbie Williams Barnes, Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11102 Eagletrace Dr, New Market, Maryland 21774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Souther Carroy other place)
Smithsburg Crematory May 30,2010 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg, Maryland re of Funeral Service Licen ee 22. Name and Address of Facility ord P.A. Funeral Home E Church St, Frederick, Maryland 23a. Part 1. Enter the shock, or heart disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Acute disease or condition Medical resulting in death) Examiner 10 years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and I-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Day 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 X No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 X No Other: ဂ္ 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 \square Pending 1 Tes Investigation neral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funeral Direct 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solarex State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 0345M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Deatl Med nT NNA rundel Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min. Apr 1 1932 Director 78 Marvland 220-28-1039 Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If firen 27 is marked other than "natural", or item. 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Oueen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 218 Beech Lane 21666 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Batchelor Louise Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Coleman (daughter) 218 Beech Lane Stevensville, MD. 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Crumpton Cemetery 5/27/10 Crumpton, MD. 21. Signature of Furier LService 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech M00510 Cross St Galena. 234 Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ BATAChNOIS disease or condition Medical resulting in death) Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, each good accause. Enter Underlying Cause (Disease or linjury that initiated events Examine Hospital or Attending Physician. The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital 2 🗆 No Other: ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred BACKWARD ON Natural Accident 5 Pending (Month, Day, Year) 1500 10 1 🗌 Yes 2 🗘 No after death

Director: A
d in by the f Investigation Sulcide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Dire

completed filled in b ome NNA Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier seputi 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cayse of death (Item 23a) (Type, Print) Jones

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

TINO2

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Patricia Lucille Beck Month 12:40 PM 2010 Mau Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Williamsport Retirement Village Washington Williamsport 8. Date of Birth (Month, Day, Year) Nov . 18 , 1 5. Social Security Number 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2x F Hours Min. 486-46-0884 69 Director Nov Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland trient of Health and Mental Hyglene.
 It att. If item 27 is marked other than "natural", or items 23a or 28a-f show that If item 27 is marked other than "natural", or items 23a or 28a-f show it into ro orlier traumatic event, the Medicial Examiner must be notified at itiny or orlier traumatic event, the Medicial Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1316 The Terrace 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces' Black, White, etc. Navy 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lester Beck Florence Wilding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Ward (Companion) 12221 West Lawn Ln. Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State May 28, Smithsburg, Maryland Smithsburg Crematory; 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 DANIS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, ta stall Nle Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Month Pregnant at time of death ed by the a detached f been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Xyes 2 No 3 Probably 4 Unknown Rm Bolism Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has page 2 2 No certificate 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 1 🔲 Yes မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 \square Pending work? Accident 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

24 hours after dear Funeral Director: filled in by completed within 2 To the

2 Medical Examiner: On the basis of examination and/or investigation, in rily opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 05 1mos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Dr Shahid Mahmood, 580 Northern Ave., Hagerstown, MD 21742

31. Date filed (Month, Day, Year) State Registra

29a. Certifier

only one)

32. Registrar's Signature

17

DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JUDITH GAYLE BUTLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medica Plata La 8. Date of Birth (Month, Day, Year) MAY 25, 1949 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days 1 □ M **X**(3)CF VIRGINIA 229-62-8686 **Director** 61 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Tyes 2X XIO Director MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 1111 STONE COURT 20602 S. A. U. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married "natural", or Maryland 21215-0036 1 □Yes XONo ģ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumetin." Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM TURNER FLESHMAN SR. GENEVA FRANCES LOWE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT BUTLER/SPOUSE 1111 STONE COURT WALDORF, MARYLAND 20602 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MAY 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State METRO . CREMATORY 26, 2010 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service License M00641 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Do not enter the mode of dyir g, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed sician and burial-tran Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical attending p for use as t IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 month Year 5 ☐ Other (specify) Ö 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use continute to the cause of death? Records, Completed by on 1 ☐ Yes 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? page 2 □Yes Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 1 Inpatient Division of 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. M. n. r of Death 28b. Time of 28d. Describe how injury occurred atural 5 ☐ Pending investigation 1 ☐ Yes 2 No 24 hours after death. Funeral Director: / 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by etermined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center 31. Date fled (Month State Registrar

(ア DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ Guy M. Conboy 11^{Day} 5:40 A_M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8900 Dyson Rd. Brandywine Prince George's Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 8,1952 9. Birthplace (State or Foreign **Funeral** Hours Washington DC 1 ★M 2 ☐ F 212-60-1144 58 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Prince George's Brandywine 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8900 Dyson Rd. 20613 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Conboy Eleanor Vanderhuf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda G. Conboy / Wife 8900 Dyson Rd., Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 105/12/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or contions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner エへいしんこ Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and de detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyperthoisn 2 No 3 Probably 4 Unknown 1 Yes Ant 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has performed? Yes 2 No renpend disease 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined e Funeral I Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and titl 29d. Date signed (Month, Day, Year) 29c. License number 20 May 12, 2010 D0066046 MD

State Registrar 31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) History, Suite 40s, Angolis, m)

32. Reg

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 15^{Day} Physician/ May 2010 ar William E. Ceglia, Sr. 4:44 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6155 Shadywood Road #207 Elkridge Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F 72 08/22/1937 Director 199-28-6115 PA Usual Residence of Decedent shov 10c. City, Town or Location 10d. Inside City Limits must be notified at Director · 28a-f 1 ☐ Yes 2 🛂 No Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 6155 Shadywood Road #207 21075 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Armed Forces? 1 ☑ Yes 2 ☐ No 1954ō 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. "natural", Specify: 3 Widowed 4 Divorced White 1966 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Manager Retail other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file nd Mental F marked or မှ Michael Ceglia Margaret Edwards and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a Donna Cavanagh - daughter 88 Barber Hill Road South Windsor, CT Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/19/2010 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 21. Signature of Euneral Service Licensee M01411 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CONCHARY ARTERY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner LABETES MELLITYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or 4EA 25 death certificate be executed HIPERLIAIDEMIA attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown P.O. ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, CIZRHOSIS OF LIVER, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed ANCIO DYSPLASIA ANEMIA Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this n 24 hours after death.

e Funeral Director, After th

bleted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Sulcide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2011 Registrar

State

29b. Signature and title of certifier

31. Date filed (Month)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EIBBONS MD

32. Fegistrar's Signature

038296

, 8186 LARK BROWNRD, SMITEZOI ELKRIDGE, MD 21075

29d. Date signed (Month, Day, Year)

May 1+

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 May 14, Cooley Lisa Marie 11:30 AM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick 8831 Seekers Walk Walkersville Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea April 18, **Funeral** 1 □ M 2**X** F Months Days Hours Min Director 220-84-4430 38 1972 Usual Residence of Decedent 28a-f show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2607 Lindell Street 20902 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No \$ 1X Never Married 2 ☐ Married Maryland 21215-0036 e filed within 72 hours after ital Hygiene. ed other than "natural", o If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked မ Bernard Cooley Thelma Bane permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Jean 19a. Informant's Name/Relationship (Type, Print) Parents 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl & Thelma Jean Cooley, 2607 Lindell Street Silver Spring, Maryland 20902 3altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 5/15/2010 4 Donation 5 Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Thomas uanta M00957 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ ciency disease or condition resulting in death) IMAGO Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, ig physician and as the burial-transi death certificate be executed that initiated events Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Wunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has the lirector, page 2 s autopsy performe death? 2 🗆 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Aunt ဂ္ဂ 1 🗌 Yes 2 XX Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manner of De th 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 \(\text{Yes} 2 🗌 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Box 68760 P.O. Records, Hospital or Attending Physician: The **Division of Vital** s after death.

I Director: After din by the fur npleted filled in 24 hours within 2

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rederic 32. Registrar's Signature State 2010 Registrar

Medical

29a. Certifier

only one) 29b. Signature and title of certif

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AL Year 1220 AM **Physician** 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Pa NURSINE TORE HOME VILL 8. Date of Birth (Month, Day, Year) 6. Sex 12 M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year Social Security Number **Funeral** Months Hours Min. 734369 Director Jersey Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedley Examiner must be notified at 1 ☐ Yes 2 No Director Prince George Capitol Heights Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2 should be filed within 72 hours after death with to and Mental Hygiene.

is marked other than "natural", or items 23a or? U.S.A. 9523 Acore Park Street 20743 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★1 Yes 2 □ No If Yes, Give Year or Date: 965 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 🛐 Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2 ¬No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Government 12th <u>Maintenace Engineer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Cuff 2 Christine Whitley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 Department of Health a Important: If item 27 is any injury or other trains 000ce. Eureka L. Cuff, wife 9523 Acore Park Street, Capitol Heights Md. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cheltenham Vet 20c. Location - City or Town, State Date Pages 1 ment of H 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/25/2010|Cheltenham, Md 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 21. Signature of Experal Service Licenses Florida Ave. NW, Washington DC 20001 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hepatric Encephalopath Physician /Medical Due to r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed for use as the burial-transit Hepatitis resulting in death) Last Due to (er as a consequence of): P.O. Box 68760, aftending physician Physician/Medical Ethanol IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Year Month signed by the a d be detached for 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2**X** No 2 No 1 ☐ Yes 1 ☐ Yes or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature J 51520 pleted cause of death (Item 23a) (Type, Print) outhern Ave 31. Date filed (Month, Dav. Year) State MAY 1 8 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Mark Wayne Clements May 15. 2010 4:28 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10721 St. Martins Neck Road **Bishopville** Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 13€ M 2□ F Director 218-42-2603 65 Nov. 1, 1944 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f shov Directo 1 ☐ Yes 2 ☑ No MD Worcester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Completed by Funeral 10721 St. Martins Neck Road 21813 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than of Health and Mental Hygiene. item 27 Is marked other than other traumatic event, Inc. M. Elementary/Secondary (0-12) 1^{College (1-4or 5+)} Business Owner Landscaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Clements ပ Katherine Fiorita 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Clements- Wife 10111 Shingle Landing Rd. Bishopville, MD 21813 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 3 Removal from State 4 Donation 5 Dother (Specify) May 17, 2010 Frankford, DE Cape Henlopen Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 24 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Debth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date sidned (Month, Day, Year) 30. Name and address completed cause of death (Item 23a) (Type, Print) of person who DN 5 20 Registrar's Signature (Month, Day, Year) 32. State MAY 1 Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day / 2 **Physician** 35M /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner omp/ex mure medica Hyattsville Prince George 8. Date of Birth (Month, Day, Year) 08/29/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min. Puerto Rico **Director** 85 580-96-1978 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Evanding must be notified at Director Yes 2 □ No Md Prince George Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3304 Lancer Drive 20782 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: Puerto Rican 1 X Yes 2 □ No 2 Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technician Hospital 12th Department of Health and Mental Hygin Important: If Item 27 is marked other I 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Tomas Rosario ပ Petronila Miranda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fredy Rosario/Son 3304 Lancer Drive, Hyattsville, Md. 20782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Fort Lincoln Cemetery 05-18-10 Brentwood, Md 21. Signature of Funeral Service License 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th. St. NE Wash. D.C. 20017 23a. Pa 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shi ci, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease o condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner cleury (failure be executed and iated events physician ar s the burial-to resulting in death) Last Due to (or as a conse Physician/Medical or Attending Physician: The law requires that the death certificate IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 23d Date of delivery atter for u 3 Ectopic pregnancy Month Day Year 5 Other (specify) Ö the 9 Unknown 9 Unknown ned by t detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ج</u> been sign should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate 2 100 1 □Yes 2 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 20 1 🔲 Inpatient Narsing Home 5 Residence 6 Other (Specify) 1 Tes 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manufer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the lest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and ma er stated 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) D0062885 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SONJA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

17

Registrar's Signat

6510 Kenilworth Ave; Riverdale, MD 20737

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Deçedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Day Month Vear **Physician** 22,2010 /Medical 4a. Facility Name (If not institution, give street and number 4b City, Town, or Socation of Death 4c. County of Deat Examiner dica Date of Birth (Month, Day, Year) 9. Birthplace Country) 7. Age (In yrs. last birthday **Funeral** Min. Months 1 M 2 ☐ F Days Hours 215,70,04 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Exyril with unsafts. 1 ☐ Yes 2 🛂 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ੬ 3 ☐ Widowed 4 ☑ Divorced MITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Soce) MD. Z1060 more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CREMATORY 4 Dopation 5 Dother (Specify) DENTON, MO UNERAL HOME 2601 MOUNTAIN AD Part 1. Enter the Modase, or washing that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYDOXIMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acirsos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown s been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy Physician: The certificate 1□Yes 2□No 2 1 No Vital 1 Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 □ Impatient 2 □ ER/Outpatient 3 □ DOA Certification: To οţ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending vision 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No nours after death.

neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Tsion Berhane BANMOU CUASMING 100 1 HL

State Registrar 31. Date filed (Month, Day,

Year!

DHMH 17 Rev 1/2001

Registrar's Signature

10-03880 Frank Debow Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rank Debow		State of Maryland / Department of Health and N 1- For State Certificate of Death	Mental Hy		2010	17101
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	2	2. Date of Death		3. Time of Death
Medical Exami		1 AMINITORN SOCIO	ation of Death	May 21, 20	10 4c. County of Dea	0110 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca 3101 Waterview Avenue Baltimore	ation of Death		do. County of Box	
Funeral		Months Dave I	f Under 24Hrs. Hours Min.	1 1	(MM/DD/YYYY) 9. B	
Director		214,54,9163 1MM 2 F 39 Yrs.	riodis Will.	9-17	-50 °	country) MD,
any	-	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits
<u> </u>	5	MD. ANNEARUNDEL GLENBURNIE	-			1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Funeral Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Co	untry?
0036 within 72 hours after death with the Maryland joine. ner than "natural", or items 23a or 28a-f she Medical Ix miner must be notified at once		412 MAPLE LANE. 2.006 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispania	nic Origin? (Spe	ecify Yes or No-	0 3.1	erican Indian, Black,
death v	nue	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Me.	exican, Puerto R	Rican, etc.)	White, etc.	/ *
s after ral", o	Ð.	3 Widowed 4 Divorced If Yes, Give Year 69-72 1 Yes 2 No spin 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (€		ork done	Specify: 16b. Kind of Busines	hiTE s/Industry
2 hour	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)			TOD. Taria of Danielos	,
5-0036 led within 77 tygiene. other than	du	12 TRAILER MECHAN	Vic .		TRUCK	IN9_
the Hyge	Be Co	17. Father's Name (First, Middle, Last) EDRAR William DEROW SR.	Mother's Name (First, Middle, M	aiden Surname)	T .
	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	nd Number or Ru	ural Route Numb	per, City or Town, Sta	te, Zip Code)
e, MD		John JEBow, ROTHER 1567 Church IA-Gi 20a. Method of Disposition (Name of cemeter	ENBURA erv.	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)		5-10	OF TO.	
Baltimo permit. Page Department Important: injury or ot	ŀ	4 Donation 5 Dther Specify: 21. Signature of Funeral Service Disensee 22. Name and Address of Funeral Service Disensee	Facility DAU	ChFRIY 9	CUERAL HO	ME.
	4	MODGILT- WOODING	NXO.M	BACENY	LMD. 2112	Approximate Interval
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atherosclerotic c.	ardious	seculor	disassa	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atheroscierotic complicated by	cocaine	intoxi	cation	
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Box 68760 e death certificate b the attending physical ed for use as the bu	M/W	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	Ectopic pregnan	псу	23d. Date of delive Month	Day Year
Sox 6876 death certificate te attending phy I for use as the b	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown				
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ords, P.O. w requires that the as been signed by should be detack	ed by	`				obably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law require is after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed			24a. Was a autops perforr	y prior to	autopsy findings available completion of cause of
tal Rec cian: The l certificate ector, page	5	26 Place of F	Death (Check or	1 Yes 2	No 1	Yes 2 No
Vital hysician this cert	o Be	examiner? Hospital: Insertingt 3 FR/Outgationt 3 DOA Othe			Residence 6 🗸 Oth	er: Scene
n of ding Ph. After ti	-	27 Manage of Dooth 28c Injury at 129c Time of Injury 28c Injury at	**	28d. Describe h unk	ow injury occurred	
Sior Attend r death ector: by the	catic	Pending Investigation Fd 5/21/10 Fd 12:45 at Yes 28e. Place of Injury - At home, farm, street, factory, office building			treet and Number or I	Rural Route Number, City
Divis	Certification:	Suicide 6X Could not be determined (Specify) Marina dock	E	or Town, St Baltimor	_{ate)} 3101 Wa1 ce, MD	Rural Route Number, City Cerview Ave
# 4 E S	e(s) and manner as st	ated. the cause(s)				
To the He within 24 To the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, decard and manner stated. 29b. Signature and title of certifier 29c. License nu		The time, date of	29d. Date signed (A	
	-	Carol Allan O.C.M.E	E.		May 21, 2010	
_		30. Name and address of person who completed cause of death (Item 23a)	MD 24204			
	2012	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, 31. Date filed (Month, Day, Year) 32. egistrar's Signature	=, IVID 21201			
Posis	tate	31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. legistrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician/ Month James Rowland Davis 11:22 May. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year) Dec 6, 1948 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9, Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Min. North Carolina 1 X M 2 🗆 F Hours **Director** 61 262-90-7783 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Carroll Westminster 1 X Yes 2 No Maryland 10f. Zip Code 0 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 21157 128 Liberty Street USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Divorced 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Billing Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ pe Mack Edison Davis Marietta Crutchfield permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Davis, wife 128 Liberty Street, Westminster, MD 21157 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Trematory or other place) any injury or 5/14/2010 Winfield, MD Carroll Crematory permit. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral 91 Willis Street, Westminster, MD 21157 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause each line Immediate Cause (Final disease or condition Physician/ resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Tyes should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performed Yes 2 has 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examinera 1 Yes 2 No Other: ဂ္ 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending ■ Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one) 29b. Signature and title of certifier 29c. License number WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hester Rd Manchoster Mil Herbert 3 WARE 7 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01:35 AM Mary C. Dell 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death MANES has ital Bastimore MD none If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 12/14/1929 1 □ M **20**XF Months Days Hours Pennsylvania 213-32-0274 80 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10a, State 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane PV304 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 3yrs Elementary/Secondary (0-12) Registered Medical Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John L. Depser Theresa O'Hara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Aslin/daughter 4D Honeybee Ct. Cockeysville, Md. 21030 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory Inc. 5/18/2010 Hanover, Md. 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licensee more 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) the letron Atrial 4 months Due to (or as a consequence of): Husertension Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to lot as a consequence of delivery Day Year to the cause of death? Probably 4 hknown autopsy findings available to completion of cause of es 2□No pecify)

Examiner requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, peen has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

Physician

/Medical

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

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Examine

Physician/Medical

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Completed

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Certification: To

Medical

3 🗌 Suicide

4 Homicide

31. Date filed (Month

Md.

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Maryland Examinat manages.

Baltimore, Maryland 21215-0036

Cause (Disease or injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ TNo 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of Month
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute
		24a. Was an autopsy prior performed?
25. Was case referred to medical examiner?	26. Place of Death ((Check only one)
1 Yes 2 No	Hospital: 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 ☐ Residence 6 ☐ Other (S
27. Manna of Death 1 Natural 5 Pending	(Month, Day, Year) Injury Work?	d. Describe how injury occurred

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number #2.40 W.7 29b, Signature and title of certifier 29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RASALES JOHN PAUL

6 Could not be determined

BALTIMORE MD 5 CATED 900

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Phillip | Payton Downell May 9, 2010 5:15 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth Birth 1943 Day, Year 28, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours 577-58-6908 **Director** 66 Vi<u>rginia</u> November Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Completed by Funeral 20018 3001 Bladensburg Road, N.E.; Apt. 409 United States Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Harkless Construction if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Company 12th grade Construction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Bikes Payton Martha Ann Downell Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Denise Brooks (Sister) 4405 - 73rd Avenue; Hyattsville, Maryland 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 15,2010 permit. Page 1
Department of
Important: If it
any injury or o of 1 X Burial 2 Cremation 3 Removal from State Landover, Maryland 4 Donation 5 Other (Specify) National Harmony Memorial Park gnature f uneral Servi x License 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, DC.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final End Stage Renal Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Acute Renal Failure Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. B B 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X** No ᅆ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? _1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury **X**Natural 5 Pending Accident Investigation after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 24 hours a Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signatuye a 29c. License number 29d. Date signed (Month, Day, Year) D006011 May 17, 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Park, M.D.;8600 Old Georgetown Road; Bethesda, Maryland 20814

State

Registrar

31. Date filed (Month, Day, Year,

9 2010

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 13^{Bay} 20ÎÖ MAY 11:05 AM TIMOTHY NEKETA DUNAWAY JR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NATIONAL INSTITUTES OF HEALTH MONTGOMERY BETHESDA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year Sept. 15, 9. Birthplace (State or Foreign Country) Virginia If Under 24 Hrs. **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Yrs , 1988 Director 225-51-1498 Sept. Usual Residence of Decedent or 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🕅 Yes 2 🗌 No VA Stafford Stafford 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 3 Halifax Court 22554 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Student University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental & Important. If item 27 is marked o any injury or other traumatic evenores. မ Timothy Neketa Dunaway, Sr. Tynnell T. Stanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22554 3 Halifax Court, Stafford, VA Timothy N. Dunaway, Sr. Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Bapt. Church May 21,2010 Triangle, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ames Funeral Home, Inc. <0208 8914 Quarry Road, Manassas, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) \leq Medical Due to (or as consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy þ Completed Certificate: To Be completed filled in by the funeral

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Hospital 24 hours

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year						
	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?						
'	osistant Enterococcus Bactereniic	1 Yes 2 No 3 Probably 4 Unknown						
Pseudomonas	Sinusitis	24a. Was an autopsy performed? 1 □ Yes 2 □ No						
25. Was case referred to medical	26. Place of Death (Che	ck only one)						
examiner? 1 🗆 Yes 2 🕱 No	Hospital: 1							
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred						
3 Suicide 6 Could not 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
(Check 2 Medical Exam	ysician: To the best of my knowledge, death occured at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurred rse Practioner: To the best of my knowledge, death occurred at the time, date and place.	at the time, date and place, and due to the cause(s) and manner state						

10

29c. License number

D0057423

MD

CENTER DRIVE, BETHESDA, MARYLAND 20892

29d. Date signed (Month, Day, Year)

13,2010

State Registrar

Medical

29b. Signature and title of certifier

KRISTIN BAIRD

31. Date filed (Month, Day, Year) 17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

To the within 7

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13, Da 2010 Year Ma^{Month} ALLEN **F.VRY** 1:00P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3116 Gracefield Road, VP#121 Montgomery Silver Spring 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 579-10-0648 1 XM 2 - F Months Hours Aug 18 1921 88 Washington.DC Director Usual Residence of Decedent show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Maryland Montgomery Silver Spring 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 3116 Gracefield Road, VP#121 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Year or Dates. WWII White 3X Widowed 4 □ Divorced "natural" other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be permit. Page 1 and 2 should be ...
permit of Health and Mental Hy.
"**arm 27 is marked by
"**aric eve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Max Evrv Anna Chidakel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 758 Palms Blvd. Venice, California 90291 Marta Evry- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Judean Memorial Gdns 5/18/2010 1 Nurial 2 Cremation 3 Removal from State Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fine al Service Licensee Bonald Wires Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions. Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE been signed by the attending should be detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Yes 2 □ No 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimers; Dementia; Diabetes Mellitus; Osteoporosis 1 ☐ Yes 2 ☐ No 3 🏲 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has I autopsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **\ \ 1**No Other: 은 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and tite of certifier 29d. Date signed (Month, Day, May 14, 2010 D44156 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rachelle Alexion, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2010

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		_1	1 - State Registrar Certificate of Death Reg. No.									
	Dii.i.		1. Decedent's Name (First, Middle	, Last)					2. Date of Deat Month		Year	3. Time of Death
	Physicia Medic	al	Janet G.	Ficken_				May	14_	2010	12:25 P ^M	
	Examin		4a. Facility Name (if not institution,					r Location of Death			nty of Death	
mar "			Brighton Garde		e (In yrs. last I	hirthday)	Columbi If Under 1 Year	a If Under 24 Hrs.	8. Date of Birth	Howa	_	place (State or Foreign
	Funeral Director		044-26-5416 Usual Residence of Decedent	1 □ M 2 🔼 F	78	Yrs.	Months Days	Hours Min.	(Month, Day, March 2,	Year) 3, 193	2 Coun	
	and show	l. I	10a. State 10b. County		10c. City, To	own or Loc	ation				1	10d. Inside City Limits
	Maryla 18a-f	rect	MD Howa	rd	El	licot	tt City					1 🗆 Yes 2 🖪 No
	a or 2 be no		10e. Street and Number		-		10f. Zip Code			10g. Citizen o		
	n with	Funeral Director	3133 Paulskir				21042				d Sta	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	Completed by Fu	11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced	If Voc Give	Ever in U.S. No		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🛣 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		ace - Americ lack, White, ^{ify:} Wh	
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21215-0036	n 72 h e. ian "n Medi	ᇤ	(Specify only higher (Specify only higher (0-12)	st grade completed) College (1-4 or	5+)	life. DO	O NOT use retired)		ang			
7	withi			4		1	Homemake				wn Ho	me
Maryland	filed tal Hy ed oth	To Be	17. Father's Name (First, Middle, L Randall Giffo						ne (First, Middle, 1 hy Swa s e		me)	
<u>₹</u>	uld be I Men narke natic	-						and Number or Rui			State Zin	Codel
Mai	2 sho th and 7 is r traun		19a. Informant's Name/Relations					irk Drive				
e,	and Healt		Richard Ficke 20a. Method of Disposition			e of Dispo	sition (Name of		Date	20c. Locatio		
nor	age 1 ant of ht: If ii y or o		1 Burial 2 Cremation 4 Donation 5 Other (5		, i		natory or other pla		/15/10	IIoo	wer.	MD
Baltimore,	nit. Partme		21. Signature of Funeral Service		_I_Arc		Cremation . Name and Addre		1/15/10 L			ily F.H. Inc
ä	permir Depar Impor any ir		Kath	1	M01411	4	112 Old (MD 21043
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cause	d the death. D	o not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition	-	entia							Onset and Death 5 years
	Medical Examiner		resulting in death)		a consequen	ce of):						-
	LXAIIIIIei	Į.	Sequentially list conditions, if any, leading to immediate	b. ————————————————————————————————————								
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68760	icate y phys is the	ledi										
Box 68	The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 reenths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pregnan Other (specify)	су			Date of delive Month	very Day Year
P.O.	law requires that the de: has been signed by the : je 2 should be detached	F.	Part II. Other significant conditi	ons contributing to death	but not resulti	ng in the u	ınderlying cause g	iven in Part I.	23e. Did to	bacco use co	ontribute to t	the cause of death?
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ord	requ been shou	ete							24a. Was a		b. Were auto	opsy findings available ompletion of cause of
ec	ne law e has age 2	l E							autop perfo	rmed2	dooth?	2 No
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Vita	ysicie is cer direct	10 B	examiner? 1 Yes 2 No	Hospital: 1 🗌 Inpa	tient 2 EF	R/Outpatier	nt 3 🗆 DOA Oth	her: 4 Nursing h	lome 5 - Resid	lence 6X	Other (Specif	ASST. LIV.
of	Attending Physician: or death. sctor: After this certific y the funeral director,	ë:	27. Manner of Death 1 ★Natural 5 □ Pendi	28a. Date of in (Month, D	ury 28 ay, Year)	Bb. Time of injury	wor	rḱ?	28d. Describe h	ow injury occ	urred	
on	eath. or: Ai	iji iji		igation				Yes 2 No	2051 11 10			al Davida Alumbar
Division of Vital Records,	or Att	Sert	4 ☐ Homicide deterr	28e. Place of Ir	jury - At home tc. (Spec <i>ify)</i>	e, farm, str	eet, factory, office		City or Tow		mber or Hura	al Route Number,
۵	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 1 Yes 2 No 28c. Injury at work? 1 Yes 2 No 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred										
	To the within 7 to the comple	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									, Day, Year)
	, ,,,		•	M	γ	ハン	D5	6531		5/	14/201	LO
	(30. Name and address of person	who completed cause of	death (Item 2	3a) (Type, I	Print)					
_	<u> </u>	1	Harry Li 8	3600 Snowden	River	Pkwy	#301	Columbia	MD 210	45		
	Sta	te	31. Date filed (Month, Day Year)	8 2010 32. Fegis	trar's Signatur	A A	10.01					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month 2010 FAYE ARABELLE FRAZIER 9:25 Ам Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Riderville Assisted Living Laurel Prince Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 🏝 F Months Days Hours Min. 84 Director Gaitherburg. 578**-**38-6554 1926 February Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Laurel 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8026 Chapel Cove Drive 20707 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 😿 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. <u></u> 1 Never Married 2 Married Maryland 21215-0036 **Black** 1 Yes 2 No Specify If Yes, Give Completed 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Government 6th uld be filed with Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Carson Burriss Rebecca Claggett other traumatic and h 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 8026 Chapel Cove Drive, Laurel, MD Ernita Martin - Daughter Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1x Burial 2 Cremation 3 Removal from State 05/15/2010 $|_{Rockville}$, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery 21. Signature Funkral Se vice Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Year shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CANCER OF LUNG WITH METASTASIS resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to jor as a consequience of that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 9 Unknown g 🗌 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ law requires Division of Vital Records, DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? The certificate 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2X No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \times Other (Specify Assisted Liv. 1 Yes 2 🔀 No ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 24 hours after death.

Funeral Director: After teted filled in by the funeral 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year MAY 1 8 2010

Syed A. Sadiq, MD, 14333 Laurel Bowie Rd., Suite 208, Laurel, Maryland 20708 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D24721

May 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per inf 2914 4-6-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month 5 03 -2810 Mae Annie Freeman P^{M} 15 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours Min. 1 2004 2 19 17 ulander, 92 579-28-8686 Director NC Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Prince Georges Lanham 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 6810 Gairlock Pl. U.S. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2 🔀 No altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black "natural" 3 😾 Widowed 4 🗌 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Food Services 6th Grade Be 17. Father's Name (First, Middle, Last) Edward R. Roscoe 18. Mother's Name (First, Middle, Maiden Surname) ည Carl L. Freeman, Sr. Britann Roscoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6810 Gairlock Pl./Lanham, MD 20706 Patricia A. Hall/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Fort Lincoln Cem. 05-10-2010 1 Burial 2 Cremation 3 Removal from State Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Murray & Tellington Funeral 21. Sign thre of Funeral Service Licenses amer Home/4804 Georgia Ave, NW/Wash., DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Septicemia disease or condition Medical resulting in death) Due to (or as a consequence of): Êxaminer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death Yes 2 X No. n signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be Advanced Dementia Completed 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate l 1 Yes 2 No 2 X No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital s after death.

al Director: After this ce Other: 1 Yes 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) HOSPice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 \square Homicide determined City or Town, State) 24 hours Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the ! only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K115/0X 05-13-2010 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Diane Ruckert, 6001 Mill Rd., Rockville, MD 20855 Muncaster 31. Date filed (Month, Day Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year Month Gladys Alice Fischer 23 5:40 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Lorien Mays Chapel Timonium . Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Days Hours (Month, Day, Year) 183-18-7767 Director 90 1920 Jan. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Baltimore Parkton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 416 Stablers Church Road 21120 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Rehmeyer Anna Mary Kashner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Stablers Church Rd., Parkton, MD 21120 Carole Baker/Step-daughter Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 27 permit. Page 1 a Department of H Important: If ite any injury or ot cemetery crematory crother place John (Sadlers) theran Cemetery 1 🛮 Burial 2 🗆 Cremation 3 🏲 Removal from State St^{ceme}John Lutheran 4 Donation 5 Other (Specify) 2010 Stewartstown, PA Signature of Funeral 8 rvice Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on inding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No for months? Day Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ EMPHUSEMA Records, 1 Yes 2 No 3 Probably 4 Unknown Completed CHRINIC KIONEY DISERSE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform PERIPHERAL Hospital or Attending Physician; The certificate I 2 \square No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) of Vital director examiner?

1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural 5 \square Pending Division 1 Tes 2 No within 24 hours after death.

To the Funeral Director; A completed filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) MH424, 2010 cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 6701 N CHARLES ST, SUITE 4105 BALTIMONEMO 2124

DHMH 17 Rev 7/2009

State Registrar DANIEUZ

31. Date filed (Month, Day, Year)

DOBERMAN, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mav 24^{ay} 2010 1:46 Ам Herbert Fisher Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Saint Clair St. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Nov. 27, 1923 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Maryland Director 86 216-14-5691 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 980 A Saint Clair St. 21742 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natura!", Specify: White 3 ▼ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Automotive Elementary/Seconday (0-12) College (1-4 or 5+) Clerk 12 Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Roy Fisher Eva Mae Herbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon L. Fisher/Son 401 Cornell Ave., Hagerstown, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 5/27/2010 any injury once. 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE ATHEROSCLEROTIC HEART Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death 2 🗆 No signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 🗌 Yes 1 Yes 2 No 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and titl 29d. Date signed (Month, Pay, Year) 20061411 1 TAGERSTOWN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE 150 ICRISHNAMODICTION 11110 MEDICAL CAMPUS RD 31. Date filed (Month, Day, Year) State

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Registrar

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10-03936 Robert Allen Gray	1	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental Hyperstrate Certificate of Death	ygiene	gible. 2010	-
Physician Medical Examine	1	1. Decedent's Name (First, Middle,Last) Robert Allen Gray Jr.	2. Date of Deat Month	Day Year	3. Time of Death 1200 hrs
Wedical Examine		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	May 23, 20	4c. County of Death	
		4726 Girton Avenue Shady Side		Anne Arundel	
Funeral Director		5. Social Security Number 214-04-7213 6. Sex 7. Age (In yrs. last birthday) With Months Days Hours Min.	8. Date of Birt	th(MM/DD/YYYY) 9. Bir Foreig 1969 Co	
nd show any ICE.		Usual Residence of Decedent 10a. State	<u> </u>		10d. Inside City Limits
rith the Maryland s 23a or 28a-f show s notified at once.		10e. Street and Number Girton 4726 Griton Ave. 10f. Zip Code 20764	10	og. Citizen of What Coul USA	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other fraumatic event, the Medical Examiner must be notified at once.	runeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No specify:		White, etc.	can Indian, Black,
urs afte tural", miner	⋧┞	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		Specify: W 16b. Kind of Business/I	
036 ithin 72 hounder than "nate"	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 College (1-4 or 5+) Marine Tech	red)	Marina	
215-0 be filed w mtal Hygie rked othe ent, the M		17. Father's Name (First, Middle, Last) Robert A. Gray Vale	(First, Middle, M		
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other fraumstic event.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route Num		, Zip Code)
re, N l and? (Health		20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
imo Pages ment of tant:	1	4 Donation 5 Other Specify: Ft. Lincoln Cemetery 5/2	-	Brentwood,	
Balt permit. Depart Impor			nnapolis	s, MD 21401	
Physician Wedical Examiner	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The properties of condition resulting in death) Due to (or as a consequence of):	r respiratory arre	est, shock, or heart	Approximate Interva Between Onset and Death
		Sequentially list conditions, b.			
	=	if any, leading to immediate Due to (or as a consequence of): (Disease or injury that initiated C			
	~ .	events resulting in death) Last Due to (or as a consequence of): d.			
be execute ician and unial - tran		X AMENDED 23a, PII, 27, per ME g905 7/1/10 10e, per FH G904 6/14/10 TT/ 19b, p	TT er Fh G	904 6/21/10	TT
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and dependent in by the funeral director, page 2 should be detached for use as the burial - transitional and professional a	SICIAII/IME	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ncy	23d. Date of delivery	day Year
P.O. Be that the de med by the detached for the med by the detached for the med by the med by the med for the med		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
P.C.	5	Chronic alcohol abuse	1 Yes		ably 4 V Unknown
of Vital Records, ng Physician: The law requir ufter this certificate has been s meral director, page 2 should been at The Committee of the control of the	Completed		24a. Was a autops perfor	sy prior to o med? death?	topsy findings available completion of cause of
Vital Recysician: The his certificate director, page		25. Was case referred to medical 26.Place of Death (Check examiner?	only one)		
of Vit Physic er this c	- ≏	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Residence 6 Other	: Scene
on of vending Physath. or: After the funeral		1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			
Division Sopital or Attendia hours after death. Interal Director: /	Certification.	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, St	Street and Number or Ru tate)	ral Route Number, City
Divis the Hospital or A hin 24 hours after the Funeral Dire mpletely filled in b	<u>,</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and concern one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.	due to the cause t the time, date a	e(s) and manner as state	ed. e cause(s)
o the	2	and manner stated.			

40+

State 31. Date filed (Month, Pay, Year) 2010

30. Nam and At ess of person who completed cause of death (Item 23a)

OCME

Assistant Medical Examiner 111 Penn Stree

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Betty Lee Gaffney 16, 2010 12:05 a M May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Westminster 996 Hacienda Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Aug 16, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗙 F Maryland 218-12-5440 86 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f sho Westminster 1 ☐ Yes 2 No Director Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21157 996 Hacienda Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 2 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher School 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Be 17. Father's Name (First, Middle, Last) Pearl Wilkens Charles Edward Geis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2290 West Valley Lane, Westminster, MD 21158 Albert Womaski, son-in-law 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. John's (Leister's) 5/19/2010 Westminster, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Lase 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, check, or heart failure. List only one cause on ach line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): perteur Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or see a consequence of): Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 1 □Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Af bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely f (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 039JO2 MD JL 54 30 Mame and address of person who completed cause of death (Item 23a) (Type, Print) - Main sheet, Westminster MD 21157 MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 📗 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 05 2010 12:37₺ Marye Lou Guyker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛣 F 10 02 1939 PA Director 70 209-30-8159 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1X Yes 2 □ No Director Prince Georges Laurel MD10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 20707 6920 Scotch Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No Specify: Specify: 2 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sallie Moosey Abraham Assad ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12511 Saber Lane Bowie, MD 20715 John Guyker, Jr./ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 15 ☐ Qther (Specify) Ft. Lincoln Crematory 05/21/2010 Brentwood, MD 21. Signature of Funery Service Lice 22. Name and Address of Facility Ft. Lincoln Funeral Home Brentwood, MD 20722 3401 Bladensburg Road 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 84mon18 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 □ Yes 2 □ Xo 1 ☐ Yes 2 ☐ No Physician; 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide * Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifle 2010 address of person who completed cause of death (Item 23a) (Type, Print) Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 14, Day 2010 Mary Margaret Godbout 5:05 a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Days Hours Min. 035-16-0751 June 19, Year 1920 Rhode Island Director 89/rs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Mary land Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 219 Randolph Road 20904 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{P} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes If Yes, Give within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Fred Rogers Ann Duffy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mary G. Teeter/Daughter 219 Randolph Road, Silver Spring, MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20c. Location - City or Town, State Date May 17 2010 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Each transfer of the Line of th 150 part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, back, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Critical Aortic Stenosis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Securities, list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical that the death certificate be Box 68760 attending for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown P.O. ģ been signed be should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate Yes 2 K No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No <u>.</u>0 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: At completed filled in by the fu death. Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) D62571 May 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Sarah Bromeland, MD 31. Date filed (Month, Day, Year) 3. Registrar's Signature State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 Michael Joseph Hazell May 09:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 66 Casparus Way E1kton Ceci1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Day Year 1 X M 2 □ F Months Days Hours Min **Director** Yrs 1959 Pennsylvania 140-48-8730 Usual Residence of Decedent show 10a. State 10b. County be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2xxxNo Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 66 Casparus Way 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Construction</u> New Homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h မ Colonel Clair Hazell t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is marke Jeanne Youngfleish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Sue Hazell / Spouse 169 Paige Lane, Elkton, Maryland 21921 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ö 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Ма¥о²¹, permit. Page Department (Important: If any injury or 4 Donation Mayerdale Crematory Other (Specify) Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear, failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner nusio Sequentially list conditions Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a so resource of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the extending heavier. been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s performed? Yes 2 No 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe hi 1 Natural 5 Pending 900 9 2010 1 Tyes Accident
Suicide Investigation 6 Could not be 28f. Location (treet and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) nome Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Monti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** :20 2010 a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner center a ar If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 KF 93 Director Virginia Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 1. S. A. Funeral . Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White Š 3 Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Home maker Own. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ OGAN NORA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau King George Va. 22485 20c. Location - City off own, State (SON FAIRSROUNDS 10358 Reginald 20a. Met od of Disposition Place of Disposition (Name of cemetery, crematory or other place Date Burial 2 ☐ Cremation 3 ☐ Removal from State Meadow-Brooke May 18,2010 King George 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Nash & SLAW F. H. P.O. BOX 33 Nind 23a. Part 1. Enter the disease, or open lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a co. equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence o attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. the 9 Unknown ģ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? page 2 death? 1 □ Yes 2 □ No certificate Hospital or Attending Physiclan: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**(X**(Vo 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Natural n 24 hours after death.

e Funeral Director: Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and time Name and address of person who completed cause of death (Item 23a) (Type, Print) Center +C enna State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day Gemmarie Hernandez May 2010 1512 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral Days Min 1 M 2 😾 Hours (Month, Day, Y Philippines Director 569-85-4723 45 Aug Ĭ964 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director Examiner must be notified 28a-f talifornia Aliso Viejo X☐ Yes 2 ☐ No Orange 10e, Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7 Barbados Drive 92656 Philippines "natural", or items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No 1 ☐ Yes ※☐ No Specify Filipino Baltimore, Maryland 21215-0036 ^{Specify:}Filipino 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Legal Secretary Walker & Mann, Ltd. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Glenda Tan Ronaldo Santos Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Danilo Hernandez (Husband) Barbados Dr. Aliso Viejo, California 92656 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 5/15/2010 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Signature Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home auli nn 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Years Dilated Cardiomyopathy Physician Ischemic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Acute Coronary Syndrame Weks Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi). Sustained Ventricular Fibrillation the burial-transi Cause (Disease or iinjury Weeks and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ρģ Pregnant at time of death 5 Other (specify) Month Day Year ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be Systemic Lupus Erythematosis Division of Vital Records, 1 🙀 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Carrier Chronic Granulomatous Disease autopsy page 2 this certificate Rhematoid Arthritis 1 Yes No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2√□ No 1 🗌 Yes မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural iniury 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Murse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year, D0038159 May 11 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) Corcoran Philip Charles 8600 Old Georgetown Rd. Bethesda, MD 20814 filed (Month, Day, Year) MAY 1 8 2010 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2010 Year Day Harris 13 May 4b. City, Town, or Location of Death 4c. County of Death

For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Reginald 7:13 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1 □**X**M 2 □ F Wash. 08/04/1942 67 .D.C. Director 579-56-8937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10a, State 10b. County with the Maryland ed trygonic and unatural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Prince George's Bowie Md. 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 20716 U.S.A. 15738 Pointer Ridge Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Important: If item 27 is marked other than "natural", or items in jujury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Deceded Armed Forces?

1 XYes 2 No 60 - 64 Black, White, etc. ð 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 Black 1 Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government 3 vears Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Helen Cash Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15738 Pointer Ridge Dr., Bowie, Maryland 20716 19a. Informant's Name/Relationship (Type, Print) Donna M. Harris/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cem. 05/26/2010 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility
H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ disease or condition Medical resulting in death) Due to fo Examiner Sequentially list conditions if any, leading to improduct cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregno 5 Other (specify) Ectopic pregnancy ate has been signed by the atter page 2 should be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Intributing to eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate hompleted filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27, Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 1 🕇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert of person who completed cause of death (Item 23a) (Type, Print) Name and addre HOSPITAL 32. Registrar's Signature State

Registrar DHMH 17 Rev 7/2009 Baltimore, Maryland 21215-0036

Department of H Important: If Ite any Injury or ot once.

burial-transi attending physician and Box 68760. Physician: The law requires that the death certificate be P.O. Division of Vital Records, this certificate After or Attending death. Director:

filled in by within 24 hours a To the Funeral C

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 2010 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deat Regional HUSPITAL Prince Geo 8. Date of Birth (Month, Day Y Nov . 30, r 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) Hours 1921 Portsmouth, Va. Months Days 1**X** M 2□ F 88 229-22-7154 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 No Maryland Prince Georges Funeral Director Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3612 25th Ave. 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. Affiled Forces
1 Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐Yes 21 No Specify. Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Steel Bender Private 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mansel May Elnora Lawrence ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Williams / Daughter 3612 25th Ave. Temple Hills, Md. 20748 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify Cheltenham, Md. May 24. 2010 Maryland Veterans 22. Name and Address of Facility
Alexander S.P.
5538 Mariboro 21. Signature of Funeral Service L ope P Pike/ A. Forestville, Md. 20747 23a. Part r. Inter the disease or complication shock, or heart failure. Unit only one car Approximate Interval Between Onset and Death complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Encephalopathy Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Decubitus Ulcers 2 40 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 1)41248 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vanbusen Rd, Laurel (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Dorrett King Humphrey May 5:15 A. 14 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital 8. Date of Birth (Month Day, Yea April 29 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** Days Hours Jamaica. Months 66 1944 Indies 579–08–0555 Director Usual Residence of Decedent or 28a-f shov notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1 X Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 20879 United States 31 Travis Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 within 72 hours after **Black** 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) National Lutheran Home Second Cook 10th grade ed other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit, Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 Naomi Brown Clifford King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31 Travis Court; Gaithersburg, Maryland 20879 Henry Adolphus Humphrey (Husband) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 29,2010 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 22. Name and Address of Facility R. N. Horton Company Morticians, gnature of Rineral Service any Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 822 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death hours Immediate Cause (Final Congestive Heart Failure Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner hours Myocardial Infarction Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Exami and -transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached t 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | þ 1 Yes 2 X No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; autopsy performed? Yes 2 N 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 X ER/Outpatient 3 IDOA ည 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending injury 1 X Natural a Hospital of 24 hours after death, ne Funeral Director: Aft 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 14, 2010 00580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.; 9901 Medical Center Drive; Rockville, Maryland 20850 Jonathan M. Wenk, 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13^{Day} Physician/ MAY Month 2010 HUGHES 12:05 P M MERITA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S 9304 DUBARRY AVENUE LANHAM 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **MAR** to, Day, Ye **SEPT** 22 6. Sex **Funeral** Hours 1 M 2 K F Days 66 67 Yrs. GEORGIA **Director** 577-<u>66-3896</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 x Yes 2 No PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9304 DUBARRY AVENUE 20706 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ٥ 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: BLACK "natural". Specify: Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12TH INFORMATION SPECIALIST GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ GEORGE HICKS BROWN GLADYS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health (item 27 i JAMES HUGHES/HUSBAND 9304 DUBARRY AVENUE LANHAM, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEME. 5/20/2010 CLINTON, MARYLAND J. B. JENKINS FUNERAL HOME Signature of Puneral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ METASTATIC RECTAL CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): inding physician and use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atter for u in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sion. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 🗌 Yes 2**X** N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check Certifying Nurse Practioner: To the best 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0040222 MAY 19, 2010 who completed cause of death (Item 23a) (Type, Print) FORD M.D. 7404 EXECUTIVE PLACE #501 LANHAM, MARYLAND 20706 State Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ 11:54a M John Han Mau Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) China 1 🗓 M 2 🗆 F Months Days Hours Min. Month, Pay, Year) 13 96 **Director** 226-56**-**8400 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 X No Takoma Park Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 u.s.A. 7906 Cole Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 7906 Cole Avenue, Takoma Park. Maryland 20912 Rosalia Y. Han - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1- 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 05/19/2010 | Silver Spring, MD Gate of Heaven Cem. Signature of Funeral Service Licensee No #1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ CORONIA Medical Examiner ROLOMVOROL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine FIBRILLATION CHRONIC To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the August Director. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To ER/Outpatient 3 X DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 \(\subseteq \text{Yes} \) 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stum Tel MD 3415 HAMILTON ST HYAFFS WILL MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 ear Physician/ May 10 1:30 am William E. Hook Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Montgomery Silver Spring 2407 Colston Drive
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth

 Months
 Days
 Hours
 Min.
 (Month, Day, Year)

 MAY
 28, 1925
 Social Security Numbe 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 1 X M 2 D F 127-16-6258 Director 84 New York Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f shot raumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 U.S.A. 2407 Colston Drive 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Art17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. Jennie Koskinen Ivar Hook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2407 Colston Drive, Silver Spring, Maryland 20910 Mary Wilmot Hook - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗀 Donation 5 🗆 Other (Specify) Judean Memorial Grdns: 05/12/2010 Olney, Maryland 21. Signature of Europa Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Cerebrovascular Disease uear Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death Tyes 2 □ No. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a. Was an autonsy After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State, Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examinar On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nyzer Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 12 May 10, 2010 D0053711 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pasquale Santini MD. 5530 Wisconsin Avenue, #1400, Chevy Chase, Maryland

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26 Day Physician/ ANTHONY WAYNE HARDY Month May 201°0 3:25 P^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
June 28,1948 9. Birthplace (State or Foreign **Funeral** 1**▼** M 2 □ F Months 217-64-7216 Hours 61 Director Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore WhiteHall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20305 W. Liberty Road 21161 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after obeartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural". or 2 1 X Never Married 2 Married Yes 2x No 1 ☐ Yes 2√X No Specify: If Yes, Give White 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) none laborer manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph F. Hardy Adelaide Lillian Lemmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Morano/PennMar Inc. Red. 310 Old Freeland Road, Freeland, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park June 1,2010 Baltimore, MD 21229 21. Signat e of eral Service in nsee 22. Name and Address of Facility 53 Main St. #CC0265 Geiple Funeral Home Inc. Glen Rock PA 17327 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final theumoni' Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed mentra attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an cate has b; page 2 sl autopsy performed this certificate Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ြု 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending thin 24 hours after death the Funeral Director. A mpleted filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2

To the I

complete only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, nace 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Chestes St, Battin une, Md 21204

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM/19a, perFH, G904, 6/21/2010, WS

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ORMAN 4:20 HARMON PM 2010 MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BEL AIR BEL AIR HEALTH + REHABILITATION HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan • 2 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Months Hours Min. Director 200-28-6906 75 Yrs. .935 Pennsylvania Jan. Usual Residence of Decedent show with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Yes 2 X No MD Baltimore Halethorpe ō 10e. Street and Numbe 10g. Citizen of What Country? items 23a Funeral 200 First Avenue 21227 USA filed within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ▼ Widowed 4 □ Divorced Specify: "natural" Completed White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 8 Landscaper Self-Employed event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o Department of Health and Menta Important: If item 27 is marked uny injury or other traumating once. ည Lawrence Harmon Anna May Strawbridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bury Burry/Daughter Andrea L. 9609 Baron Place, Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Presbyterian Cemetery May 28, 2010 New Park, PA21. Signa Puneral Selvice License 22. Name and Address of Facility J.J. Hartenstein Mortuary Inc South Main Street, Stewartstown, PA 17363 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as codiac or respiratory arrest, Approximate shock, or heart failure. List only one cause or each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of): Examiner 00 5 12/8 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Du to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown ☐ Unknown ontributing to death but not resulting in the underlying cause give<u>n in</u> Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has page 2 autopsy performed this certificate 1 Yes Yes 2 Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Nes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature Date signed (Month, Day, Year) Name and a who completed cause of death (Item 23a) (Type, Print) rar's Signature State Registrar

ORIGINAL

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ARMON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year MAY 27, 2010 5:15A **Physician** MARY ELZENE HICKS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES 410 GARNER AVENUE WALDORF Birthplace (State or Foreign MD • 8. Date of Birth (Month, Day, Yes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖫 F 92 218-30-4573 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, I'm "Malcal Expringer man be notified at 10h County 10c. City, Town or Location 10a State 1 ☐ Yes 2X No LA PLATA Director MD. CHARLES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20646 6130 BIVINS PLACE Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 □Yes 2 □Xo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify:BLACK 1 ☐ Yes 2 ☐ No Specify: 2 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOMES DOMESTIC CLEANER 5th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELLA SCRIBER FRANK FARMER ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trauonce. WALDORF, MD. AGNES O.MUSCHETTE-SISTER 4037 BLUEBIRD DR. Baltimore. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition SACRED HEART CEM. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-4-2010 LA PLATA, MD. 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Fureral Service Licensee M00479 PLATA, MARYLAND 23a. Part 1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COLON Physician once /Medical Due to (or as a consequence of): Examiner Cereboo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and Due to (or as a consequence of) burialaftending physician for use as the burial Box 68760, Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has certificate 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 NOther (Specify) ASS 7- Live Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Deat 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death. Funeral Director: After the 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined filled in by 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 35 DR KRISHAN M. MATHUR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2^{Day}, Helen R. Hoffman 2010 6:05 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) May 29, 1921 1 □ M 2 ☐ F Months Hours Min. 220-07-8789 Director 88 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 1 Tes 2X No MD Baltimore Parkton 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 20861 Old York Road 21120 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ð 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 XWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Word Processor Electronics is marked other Be Page 1 and 2 should be filed ment of Health and Mental Hy Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence R. Simpson Mary Enfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Frederick / Son 18908 Old York Road, Parkton, MD 21120 Department of Health Important: If item 21 any injury or other to once. Baltimore, Date 28, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Wiseburg Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 White Hall, MD 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. tech 24 N. Second St., New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or illingary that initiated events Due to (or as a consequence of): burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Dav Year a \ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) injury 5 Pending 2 Acciden
3 Suicide Accident Investigation M 1 Yes 2 No the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital (Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date signed Month, Day, Year) 20/0 erson who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32 Registrar's Signature State Registrar

P DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0415 M Josephine Joanna Johnston 05 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICIMION TRAINSHIA BRAIDNAL SALISBUM If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Min. 2/8/I92 Hours Director 88 391-16-6272 Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medital Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Wicomico Salsibury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 Booth St. 21801 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: and Mental Hygiene. If Yes, Give 3 ⋈ Widowed 4 □ Divorced Year or Dates. white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Michael Farina Sarah Nastasi 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Andrews / daughter Spring Crest Dr., Salsibury, MD 21804 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of h Page 1 cemetery, crematory or other place) 1 D Burial 2 Dremation 3 Removal from State 5/14/2010 Frankford, DE 4 Donation 5 Other (Specify) Cape Henlopen Cremi. 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications of t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). Exami and I-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical that the death certificate be attending phys for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation To the Hospital or Atter within 24 hours after der To the Funeral Director completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 29c. License number D63199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA3 St. SAlisbury md 21801 100 E. CARROLL VOHRA mb

Registrar DHMH 17 Rev 7/2009

68760

Box

P.O.

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.													
			State of Maryland / Department of Health and Mer						ental Hygiene				
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	Funeral Director		579–26–5134	85 Yr	Month		Hours Min.	8. Date of Bird (Month, Da	e of Birth 9. Birthplace (State or Foreign Country) /20/1924 Washington, DC				
	D ow		Usual Residence of Decedent						- Wasi				
	aryland a-f sh fied a	Director	10a. State 10b. County	10c. City, Town o	or Location						10d. Inside City 1X Yes 2		
	or 28 e noti	Dire	Maryland Prince George's 10e. Street and Number	Bowie	10f. Z	Zip Code			10g. Cit	tizen of What Co			
	s 23a	Funeral	6307 Gibralter Court			20720			Unit	ed Stat	es		
	death item		Armed Forces?	Was Decedent Ever in U.S. Armed Forces? 13. W		edent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	y Yes or No- can, etc.) 14. Race - Am Black, Wh				
Baltimore, Maryland 21215-0036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heatth and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗶 No If Yes, Give Year or Dates.							Specify: B1a	_		
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yla	uld be I Ment narke	잍	Jesse James Ashton Jr.				Bernic	e Waugh					
Ma	12 should lith and Me 27 is mar		19a. Informant's Name/Relationship (Type, Print) Jessica Ashton / Grand Dau		_		nd Number or Rur						
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<u>m</u>	Page nent c ant: If ury or		1 Burial 2 ☐ Cremation 3 ☐ Removal from State Graph of the (Specify)	Fort L	incoln			/2010	Bre	ntwood.	Marylan	d	
3alti	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signa are of Funeral Service Livensee		22. Name	and Address	s of Facility Pop	e Funer	al H	omes, P	.A.		
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disease or condition resulting in death) disease or condition resulting in death) a. CARDIOPULMUNARY FAILURE Due to (or as a consequence of):												_	
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<u>P</u> .	s that gned I be det	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASPIRATION PNEUMONIA						obacco use contribute to the cause of death?				
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eco	e law i e has b ge 2 s	ldmc	STROKE						24a. Was an autopsy performed? 1 ☐ Yes 2 【XNo 2 2X No 24b. Were autopsy findings averaged prior to completion of cardeath? 1 ☐ Yes 2 [X] No				
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Vit s	nysicia nis cer direc	မ		ent 2 🗆 ER/Outp	atient 3 🗆	Other			dence 6	Other (Spec	ify)		
Division of Vital Records, P.O.	I or Attending Physician: The law after death. Director: After this certificate has in by the funeral director, page 2 in by the funeral director, page 2.		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation			28c. Injury work?	at	28d. Describe h					
visio	or Atter	Certificate:	3 Suicide 6 Could not be 28e. Place of Inju					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier (Check (Check 2 Medical Examiner; On the basis of examiner)	date and place, an	e, and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s) and manner sta				er stated.				
	o the lithin 2 orthe orthe orthe orthe	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and p 29b. Signature and the of certifier 29c. License number					ace, and due to the cause(s) and manner a 29d. Date signed (Mon			stated.		
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	100		30. Name and address of person who completed cause of de										
مين	Y-/-		Bahram Pishdad 7420 Mar1bo 31. Date filed (Month, Day, Year) 32. Registra	ro Pike	Forest	ville	, Maryla	nd 2074	7				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY 2010 Year JOHNSON 3:38 P M **EMMA** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🖫 F (Month, Day, Hours Min. MARYLAND **Director** 578**-**40-1019 show 10a. State 10h. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1450 NOVA AVENUE 20743 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married δ 1 ☐ Yes 2 💢 No Maryland 21215-0036 and Mental Hygiene. is marked other than "natural", If Yes, Give 1 ☐ Yes 2 X No Specify. BLACK 3 → Widowed 4 □ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8TH PRIVATE HOUSEWIFE Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve HARRY HYSON EMMA C. BOWIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1450 NOVA AVENUE CAPITOL HEIGHTS, MARYLAND 20743 AANDRA JOHNSON/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 5/18/2010 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B.JENKINS FUNERAL HOME Signature of Funeral Service Liçensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury Exam Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒️No 24a. Was an certificate has page 2 autopsy 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No မ 1 Tes 1 Inpatient 2 FR/Outpatient 3 DOA After this 27. Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \sum Yes 2 \sum No 1 X Natural injury 5 Pending within 24 hours after death.

To the Funeral Director; A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an 29c. License number o completed cause of death (Item 23a) Type Print) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Milton Jacobs Day 2010 Year May th 13, 6:25Р. м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Rockville Hebrew Home of Greater Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Days Hours AMenth 9 ay 1 9 20 174-12-9771 89 Pennsylvania Director Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Rockville Montgomery 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6105 Montrose Road 20850 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced WWII Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Jacobs Sarah Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4201 Cathedral Avenue, N.W., T6E Washington, D.C. 20 Colette Jacobs -wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Mt. Lebanon Cemetery 5/17/2010 Adelphi, Maryland 21. Signature of Functor Service License Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Premovie Aspiration disease or condition Medical resulting in death) Examiner Due to for as a consequence of Stape Jaquantiany fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 2 X No Yes 2 X No 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at within 24 hours after death, To the Funeral Director: After completed filled in by the funer 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier miron Fir Zh 5-14-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Fazli,

Mina

31. Date filed (Month, Day, Year)

Montrose

6105

Rockville,

MD 20852

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 5/7/2010 CLARENCE JOHNSON JR. P^{M} 5:13 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5715 Linda Lane Prince George's Camp Springs Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
New Orleans, 1 🔀 M 2 🗆 F Months Days Hours (Month, Day, Yea 3/23/194 **Director** 437-58-2946 67 Usual Residence of Decedent 28a-f show 10b. County 10c. City. Town or Location 10d, Inside City Limits Director notified 1 X Yes 2 No Maryland Prince George's Camp Springs items 23a or ner must be n ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5715 Linda Lane 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner r 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 TM Married 1x Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates Black 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the other Metro Police Officer WMATA GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F is marked of ပ Clarence Johnson Gladys Williams 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 i Maxine Johnson / Wife Linda Lane Camp Springs. Marvland 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1; Date o = 6 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: It any injury or once, Maryland Veterans 5/14/2010 Cheltenham, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Service Lice 5538 Marlbroro Pike Forestville, Maryland 20747 120010 Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death YEAR Physician/ disease or condition resulting in death) NON SMALL CELL LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1XXYes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 😾 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058924 May 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6900 Georgia David C. Van Echo Ave. NW Washington, DC 20307 (Month, Day, Year) AY 1 9 2010 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

P.O. Box 68760

Division of Vital Records,

10-03841 Barbara Kuhfahl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Barbara Kuhfahl		S 1- For State Registrar	tate of Marylan		rtment of tificate of		d Mental I	-	2 Reg. No.	010	17135
Physicia Medical Examir	n/	Decedent's Name (First, Midd Barbara Kuhfal				-		2. Date of De Month May 19, 2	ath Day	Year	3. Time of Death 1632 hrs
)		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Death Annapolis							4c. Co	ounty of Dea	
Funeral		Social Security Number		Age (In yrs, la	st birthday)	If Under 1 Year	+				tirthplace (State or
Director		213-78-9726	1 M 2 F	50	Yrs	Months Days	Hours M	06/21/	1959	C	ountry) Maryland
v any	ŀ	Usual Residence of Decedent 10a. State 10b. County			Town or Locat	ion					10d. Inside City Limits
ryland a-f shov	tot	Maryland Anne 10e. Street and Number	Arundel	Edg	gewater	10f. Zip Code			10a Citizen	of What Co	1 Yes 2 No
the Ma 3a or 28	Director	1717 A Elkridge	e Dr.			21037			USA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 N		es?		s Decedent of His es, specify Cuban,			0- 14.	Race - Ame White, etc.	erican Indian, Black,
s after d iral", or	ক্র	Λ	1 Yes vorced If Yes, Give Year or Dates:	2 X No		Yes 2X No					White
72 hour	Completed	15. Decedent's Education (Special Elementary/Secondary (0-12)			during m	t's Usual Occupati ost of working life.				of Business	
-003(d within griene. ther tha	omo:	12. Father's Name (First, Middle	e Last)		Wai	itress	8 Mother's Nam	ne (First, Middle,		estaura	int
1215 d be file ental Hy arked o	<u>8</u>	James Carpent	ter				Mary C	arpenter		·	
Baltimore, MD 21215-0036 bernit Pages I and 3 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumatic event, the Medica	٩	19a. Informant's Name/Relation Heather Palmieri-				Address (Street kton Rd., (r Town, Stat	te, Zip Code)
or Healt of Healt If item		20a. Method of Disposition 1 Burial 2 V Crematio	n 3 Removal from	State cr	ematory or oth			Date			or Town, State
nit. Pag artment ortant:	-	4 Donation 5 Other S 21. Signature of Furferal Service		Balt		ashington (y 22, 2010	Laur	el, Mar	yland
		23a. Part I. Enter the disease, o	M01234		Fle 76	ck Funeral Ol Sandy Sp	Home, IN	C. , <u>Laurel,</u>	Maryla	nd 2070	07
Physician M		failure. List only one cause Immediate Cause (Final disease	on each line.								Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a co								
	iner	Sequentially list conditions, if any triading to immediate cause. Enter Underlying Cause	Due to (or as a co	nse pronce of							
ed nsit	dical Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
0, e be executed sician and burial - transit	dical	X UNPENDED	AMENDED	ner ME		6/22/10	 ТТ				
	Φ ⊩	IF FEMALE: 23b. Was decedent pregnant in t	200. II yes, out	come of pregna	aricy	al death 3	Ectopic pregr	nancy	23d. Da	ate of delive	ry Day Year
Box 6876(e death certificate the attending physed for use as the b	Physician/M	past 12 months? 1 Yes 2 No 9 ✓ Un		t at time of deat	- H	ner (Specify)					
P.O. Eles that the designed by the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									o the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. Tal Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.								1Ye			obably 4 Unknown
ecords, he law requin te has been si	Completed							auto perfo	rmed?	prior to death? 1 🗸 Y	
Vital Rec ysician: The l his certificate I director, page	å	25. Was case referred to medica examiner?	- Hospital:				of Death (Check	only one)			
n of Vi ding Physi After this funeral dii	위	1 Yes 2 No 27. Manner of Death	28a. Date of I	atient 2 🗸 E	R/Outpatient 28b. Time of Ir		at Work?	ing Home 5	Residence how injury o		er:
ivision or Attendia after death. Director: A	ertification:	1 Natural 5 Pen 2 Accident Inve	ding estigation	=	- form show	-	es 2 No	00(1)	0		ort Do to North or Oit.
Division spiral or Attendours after death neral Director: filled in by the	Certifi		Id not be (Specify)	r injury - At non	ne, rarm, stree	t, factory, office bu	iliaing, etc.	or Town,		Number or K	tural Route Number, City
8 4 5 5	Medical ((-	-		occurred at the time, date and place, and due to the cause(s) and manner as stated. stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)					
To with To com	Med	29b. Signature and title of certific	and manner state er	ed	1	29c. License	number		29d. Date	signed (Me	onth, Day, Year)
		30. Name and address of person	1 M	of death (learn 2	39)	O.C.M	1.E.		May 20), 2010	
		Zabiullah Ali, M.D.	Assistant Medical	Examiner	111 Peni	n Street, Baltir	more, MD 2	1201			
Sta Registr	ite rar	31. Date filed (Month PayYez)	K 70301 A	trar's Signature	A. 40	we					
					-				OCN	ΛE	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month IRB ATHERINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NWA POLI DUNRISE SSISTED -1 VING 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Washington DC Months 93 **Director** 214-05-0629 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** Funeral 21401 1558 Ritchie Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XXIVo Specify: If Yes, Give White Completed 3XX Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Naval Academy Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ည Josephine Boswell Eligius Roelle permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Winchester III - Son P.O. Box 129, Galesville, MD 20765 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State BaltimoreCrematory 5/14/2010 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home Mischin T. Whole I 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Ouset and Death Immediate Cause (Final ARKINSONS Ph_sician/ VOMPE disease or condition resulting in death) Medical Due to (or as a consequence of Examiner S. cuentially internal life in if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): cal Division of Vital Records, P.O. Box 68760 Physician/Medi yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Dáv Year 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed plnous peen PERTONSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performe After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to dical examiner? Be 26. Place of Death (Check only one) ASSISTED 2 1 No Hospital Other: UNNE ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manher stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifi 2 address of person who completed cause of death (Item 23a) (Type, F 10

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>010</u> Physician/ Month May Christobelle Virginia Kelley 12 1358 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olneu Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Country) Virginia 1 □ M 2 🗓 F Days Months Hours Director 218-56-5871 91 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15101 Interlachen Drive, Apt. 20906 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grover Cleveland Godfrey Mary Lillian Gertrude Heflin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda J. Zimmerman - Daughter 2445 Rippling Brook Road, Frederick, MD 21701 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Denation 5 Other (Seecify) Lincoln Crematory 05/18/2010 | Brentwood, Maryland 21. Signature of Fundral Servico Lina nsee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 11800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any local glown led cause. Enter Underlying Cause (Disease or iinjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 9 Unknown g Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 욘 1 Inpatient 2 PER/Outpatient 3 IDOA After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation Director; 6 Could not be within 24 hours after de To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gretifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month. Day. Year) 1050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BERNARD RICHARD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY WESTERN MD REGIONAL MEDICAL CENTER CUMBERLAND If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) 01 23 1957 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Yrs. Director 233-92-0199 53 MARYL AND Usual Residence of Decedent or 28a-f show 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ALLEGANY FROSTBURG MD 1 Yes 2 No 10e, Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 11 FEDERAL STREET 21532 U.S.A. ral", or items? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. ğ 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) PRODUCT INSPECTOR HUNTER DOUGLAS permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ELSTE SMITH LARUE WILLARD RICHARD LARUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 FEDERAL STREET FROSTBURG, MD 21532 ELIZABETH LaRUE WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State CUMBERLAND CREMATORY 05-29-2010 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. Sower M00547 60 W. MAIN STREET FROSTBURG 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ocandial disease or condition ours Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Dire to (or as a nonsequence of) cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ igned by the atter be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 交 Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy al or Attending Physician: The safter death.

I Director: After this certificate I 1 Yes 2 No Yes 2 L funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 \(\text{Yes} 2 🗌 No by the f Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 1121244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) roadwa lan 32 Registrar's Signature State CB22-6. Registrar

DHMH 17 Rev 7/2009

214

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lebherz Patricia Lynn Mav 11:28 AM^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick 1204 Oakwood Drive Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F Months Days Hours Min. May 27, Yel 953 Maryland Director 212-64-2386 56 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Frederick Frederick Maryland 1 X Yes 2 ☐ No 10f. Zip Code 21701 10e. Street and Number 10g. Citizen of What Country? Funeral 1204 Oakwood Drive U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joan Baker Marvin Lloyd Hiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 Oakwood Drive, Frederick, MD 21701 Charles F. Lebherz, husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory May 26, 2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) of Fixeral Service Lic Keeney and Basford PA Funeral Home 106 East Church St., Frederick, M 21. Signatu M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death 144 Physician 40717 disease or condition resulting in death) 189Y Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☑ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 100 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 294225 May 25, 2010 address of person who completed cause of death (Item 23a) (Type, Print) e and 9093 Ridgolield Brive suit iarkou سرام 31. Date filed (Month, Da), Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 113 rundel (SEN A If Under 1 Year | If Under 24 Hrs. 6. Sex Funeral Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 1 F Days Hours Min ^{Year)}948 JUNE, Day MARYTAND 215 56 1651 62 Director Yrs. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Director or 28a-f sh notified 1 ☐ Yes 2 🕅 No ANNE ARUNDEL **EDGEWATER** MARYLAND 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 1628 SHORE DRIVE 21037 UNITED STATES if Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 M Married 1 ☐ Yes 2 🏋 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FEDERAL GOVERNMENT CLERK 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1628 SHORE DRIVE EDGEWATER MARYLAND PAUL E. McINTIRE (HUSBAND) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot . Page 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) KALAS CREMATORY 05-12-2010 EDGEWATER MARYLAND 21. Signature of Funeral Sorvice Vicen 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER.MD. a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death , or heart failure. List only one cause mate Cause (Final Physician/ KYID 5 C disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and the for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 **Z** Yes Hospital: Other: 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier epute 29d. Date signed (Month, Day, Year) 0603 pleted cause of death (Item 23a) (Type, Print) ONES m

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 May 5:40 PM Brian John Miller /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Westitue 15 Constitution of the following state of Birth (Month, Day, Year)

Months Days Hours Min. July 21, 1953 Carroll Carroll Hospice Dove House 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 🗆 F New York Director 56 <u> 147-48-9218</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, Ite Modeal Expression and the traumatic at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Westminster Director Carroll 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 490 Dotsie Dr. Funeral 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Specify: <u>Ş</u> Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Realtor Balsley-Losco Realty 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Finn Joseph Miller ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Bayview Dr., Absecon, NJ 08201 Matthew Miller/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation Inc. 05/14/2010 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Pritts Funeral Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician terai neumonia 151 resulting in death) Medical Due to (or as a consequence of) Examiner espira Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No n signed by the Id be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Twh BIYA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an After this certificate has page 2 autopsy 1 □Yes 2 DN director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 MOther (Specify) HOSPICE funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

neral Director; A
filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 139JO2 MM

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Registrar

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and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Hosam

Year,

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Maxwell 2010 Antoinette Мау 7:35 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital 01ney Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛭 F Months Days Hours Min. Director 579-84-3932 45 9 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Silver Springs MdMontgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2601 Bel Pre Road 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give than "natural", 3 Divorced Specify Completed Year or Dates. Black other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Food Cashier 8 Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louisa Simpkins Harvey Maxwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is 14200 Farnsworth Dr., Upper Marlboro, Md. Louisa Simpkins/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, injury or 4 Donation 5 Other (Specify) 5/17/10 Riverdale, Md. Riverdale Signature of Funeral Service Licensee 22. Name and Address of Facility Bluford Funeral Service Ave., SE, Wash.DC 2019 Martin Luther King, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 20 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examine Due to lor as a consequence of cause. Enter Underlying physician and s the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Number Practicion: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ause(s) and mariner as states 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0050410 14/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip De Olnes 32. Régistrar's Signature State MAY 17 2010 Registrar

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Baltimore, Maryland 21215-0036

68760

Box

P.0.

Records,

Division of Vital

State Registrar

DHMH 17 Rev 7/2009

Nicholas W. Koutrelakos, M.D. 10710 Charter Drive Suite G020 Columbia, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Rofus 11:00 P M Allen McDonald 2010 Medical Mav 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dove House <u>Westminster</u> Carrol 1 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Year 1937 1 XM 2 I F Days Min. sept 25 Georgia Director 72 258-52-5479 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director NC Martin Oak City 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 1210 David Brown Road 27857 United States 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
item 27 is marked other than "natural" as itema- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANO Specify: If Yes, Give Year or Dates. 1958–61 Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 <u>Engineer</u> Diesel/Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ralston v. McDonald Audrey More traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27857Wesley Paul McDonald, Sr./son 1210 David Brown Road Oak City, North Carolina injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date . Page 1 Department of h Important: If its any injury or of once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/18/2010 Woodbine, Maryland 21. Si ure of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death Physician, Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of): the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicis mpleted filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Trobably 1 Yes 2 No 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion death? performed 1 Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be within 24 hours after de:

To the Funeral Director

completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Dav. Year) License number address of person who completed cause of death (Item 23a) (Type, Print) 5+1 gistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

A 26 20th

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death Deceder nt's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day **Physician** 5/24/2010 8:17 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 700 PORT ST., UNIT 208 **EASTON TALBOT** If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** 1 M 2 XF Months Davs Hours Min. MÁRYLAND Director 213-24-0727 7/3/1928 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene.

marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f sho event, the Medical Examinar must be notified at Director 1 XYes 2 □ No MARYLAND **TALBOT EASTON** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 700 PORT ST., UNIT 208 2160I Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11, Marital Status Black, White, etc 1 XYes 2 If Yes, Give 2 No 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 XNo Specify Specify. ≥ 3 Widowed 4 Divorced WHITE Year or Dates: 1957 - 1975 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AIR FORCE OFFICER **MILITARY** 6 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be JAMIE PATTISON MILLS, SR. CORA AMELIA LEONARD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLE T. LIVINGSTON / NIECE 417 CAMBRIDGE LANDING, CAMBRIDGE, MD 21613 Baltimore, Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 XCremation 3 ☐ Removal from State 5/27/2010 4 ☐ Donation 5 ☐ Other (Specify) EASTERN SHORE VETERANS CEMETERY HURLOCK, MD 21. Signature of Fun 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 IHIGH ST., CAMBRIDGE, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** anc months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physiciar Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ó in the past 12 mont Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) P.0. the detached 9 Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 2 1No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 NO 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY ANN D. MOORE, MD, 300 DORCHESTER AVE., CAMBRIDGE, MD 21613-2420 31. Date filed (Month, Day) Vear)-32. Registar's Signature State Registrar

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 12, Physician/ Elizabeth Ridgely Gaither Ochs 3:34 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min 5/19/1928 219-26-1342 Maryland 81 **Director** Usual Residence of Decedent 28a-f show 10b. County Anne Arundel 10d. Inside City Limits Examiner must be notified at Maryland 10c. City, Town or Location Director Annapolis 1 ☐ Yes 2X No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** Funeral 2519 Carrollton Road 21403 items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Force Black, White, etc "natural", or ģ 1 Never Married 2 X Married Yes 2X X No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Meaonce. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy Bassford Ridgely Gaither Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2519 Carrollton Road, Annapolis, MD 21403 William Ochs Jr. - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Arlington National Cem. 7/16/2010 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Muchin T. Velober 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the bunal-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit cmorth Cause (Disease or iiniury that initiated events Due to (or as a consequence resulting in death) Last vasculo Congulganth Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Pregnant at time of death 1 ☐ Yes ∠ u g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury **™** Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d, Date signed (Month, Day, Year) 29c. License number D0005829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOW ARD loung Me Anne Arund el

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OS Year Physician/ EUGENE AM 11:51 ZOID Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY OF MARYLAND MEDICAL Social Security Number 7. Age (In yrs. last birthday) 53 yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months 220-70-2181 1 🙀 M 2 🗆 F 3/24, 71957 Country) Nevada Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Maryland Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21701 123 East Patrick Street by Funeral 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian 1 X Never Married 2 Married 1 Yes 2 🕱 No ental Hygiene.

--ther than "natural", o Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Interior Designer Be 18. Mother's Name (First, Middle, Maiden Surname)
Doris Diane Purdy 17. Father's Name (First, Middle, Last) ပ Eugene E. Paro Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 145 Wallace Manor Road, Edgewater, MD 21037 Diane Ogden - Mother Page 1 and 2 sment of Health amut: If item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 🔀 Cremation 3 🗌 Removal from State 5/18/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Mighin T. Whobert 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Stage liver disease or condition resulting in death) Medical Due to (or as a co a guence of) Examiner neumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed anding physician and use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) 1 Yes 2 No signed by the aid be detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law in 24 hours after death.

the Funeral Director: After this certificate has k autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1110 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural
Accident
Suicide 5 Pending 1 \(\text{Yes} 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ٥ P24416 12010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, BATIMERE, MD 225. GREFNE NAYAR State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nd 20b c per Fh G904 6/4/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 9, 2010 May 12:00 A M EMANUEL PERSAUD, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kensington Montgomery Kensington Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | September 5, 1937 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2 □ F 72 578-96-2583 Guyana, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show r 28a-f show notified at 1X Yes 2 □ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be 20011 USA 910 Webster Street, NW death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married _{Specify:}East Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. δ 3 ☐ Widowed 4K Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2 Years and Mental Hygiene. Elementary/Secondary (0-12) Real Estate Self-Employed or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe Sarah Nankusher Ganga Persaud permit. Pages 1 and 2 should I Department of Health and Ment Important: If item 27 is marked 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 203 Castleton Terrace, Upper Marlboro, MD 20744 Emanuel Persaud, Jr. - Son Brentwood, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington Cemetery Lincoln Cemetery May 17, 2010 Adelphi, Maryland injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licensee 716 Kennedy Street, NW, Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) etherosclerotic ardiovascular disease **Physician** unknown / /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 2□No 9□Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Kementia Cexelyovasular accident, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed Diahetes Mellitus, Chronic Kidney disease; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Hypertension, Chronic anemia, Gastric mass 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? or Attending Physician: 24 hours after death.

E Funeral Director, After this certific letely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; Injury 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 043/21 Chowde

CP 4

State 31. Date filed Registrar

31. Date filed (Month, Day, Year)

NAY 1 8 2010

Annual May 1 8 2010

30. Name and address of person who completed use of death (Item 23a) (Type, Print)

RY, MD; 15216 DINO DRIVE; BURTONSVILLE, MD 20866

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ICKENS ALVIN Month Year 2010 9:54 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Onley Montgomery 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🕱 M 2 🗆 F Months Hours Min Country) unknown Director Yrs. 427-68-6537 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If lene 27 is marked other than "natural", or items 23a or 28a-f sho many injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20906 United States 2601 Bel Pre Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status unknown Was Deceden... Armed Forces? ¹ ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th unknown unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Alvin Pickens unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eli Guiterman/ Guardian 2120 L Street NW Suite 700 Washington. 20037 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 2010 Clinton, Maryland nature of Funeral Service L 22. Name and Address of Facility Stewart Funeral Home, Benning Rd. NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician SEPSIS Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 2 PNo 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျင 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 1 within 2 To the 1 3 only one) 29c. License number 29d. Date signed (Month, Day, Year) H0065661 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah Stein, Do. 18101 Prince Phillips Drive Olney, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 A 2010 Registrar

DHMH 17 Rev 7/2009

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Amend #7 & 8 per Inf G904 6/7/10 TT & #2 per MD

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Peath Month 11, 3. Time of Death Physician/ BETTY ELIZABETH PROCTOR 2010 1933 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. 1 M 2 F Months 2/19/19291926 New York, 83 <u>ea</u> Yrs **Director** 217-42-4715 Usual Residence of Decedent 28a-f show 10b. County filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 X Yes 2 No Prince George's Maryland Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15104 Brandywine Rd. 20613 United States items "natural", or item edical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2x No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 ₩ Widowed 4 Divorced Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the t. Page 1 and 2 should be filed with rtment of Health and Mental Hygien rtant: If item 27 is marked other 1 njury or other traumatic event, th Retail Saleperson Be 17. Father's Name (First, Middle, Last) IJNK 18. Mother's Name (First, Middle, Maiden Surname) 0 Mary Kerrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria C. Butler / Daughter 4622 Dowell Lane Suitland, Maryland 20746 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 5/24/2010 Alexandria, VA 21. Sign re of Funeral Service Livenses 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 16 Caro Medical resulting in death) Due to (or as consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending attending the second of the secon the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ate has been signed by the atte page 2 should be detached for Day Year Pregnant at time of death 1 Yes 2 g 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 🗆 No 1 Yes |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred / Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) rasimr State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ PINDER Day & Year 2010 01:39 AM SHIRLEY STRONG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMONE a of manino medical conten If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Sept 4 Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. 1927 82 Maryland Director 215-20-1984 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Examiner must be Funeral 23a with 122 Clipper Way 21620 U.S.A. items: 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò ð 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 'natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u> Ironer/Presser</u> Shirt Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Ringgold Strong Minnie Armbruster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy Unruh (daughter) 10119 Flatland Rd. Chestertown, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Kent Cremation 4 Donation 5 Other (Specify) 5/28/10 Smyrna, DE. - Free Servic Licers 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 21. Sign 102 M00510 118 West Cross St Galena, Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or respiratory. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Qause (Final ASPIRATION Physician/ diseas condition resulting in death) Medical Due to (or as a consequence of): X GALS ITS PUT EXPLINAN Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury Exami ALTIC that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): bunal physician Medical Box 68760 the attending philosophia IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 ☐ Unknown ed by the a 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen NUTRITIONAL STATUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No Yes 2 or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 00 ည 1, Inpatient 2 I ER/Outpatient 3 I DOA this funeral 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After the pleted filled in by the funeral 1 Natural (Month, Day, Year) 5 🗌 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24

To the F

complet only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar SI GREENE ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

32. Registrar's Signature

JESTEN

ADAM

31. Date filed (Month, Deu Year) 0 2 201

P24401

BALTIMONE

5/28/2010

2120)

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Amonth 1 2°0°10 Louise Reed 1447 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Anne Arundel Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Maurity) 1 and **Funeral** 1 M 2 V F Months Days Hours Min. JuMonth, Day, Year) 1925 219-12-3963 84 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 611 Greenbriar Lane 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 72 hours after ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3X Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11th 0 Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Laverna Taylor Clinton Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Amelia White(Daughter) Heritage Ct. Annapolis, Md. 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5-5-10 Maryland Veteran Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 20 Marne a Rocans Schr & Scilit Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Yary B. Reese MOOF 83 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final athero Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) -transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Pregnant at time of death Month Day Year Yes 2 No the be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has page performed? 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: မြ 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 Year 13, Ronald E. Riegel May Medical 11:30 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HeartHomes Pasadena Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F (Month, Day, Y Months 310-14-8625 Hours Min. 86 Director Indiana Nov. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at **Funeral Director** 10d. Inside City Limits Anne Arundel Severna Park 1 Yes 2 X No ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 601 Isaiah Drive Severna Park USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1X Yes 2 □ No WWII 0 Completed by Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", If Yes, Give Specify: 3 X Widowed 4 Divorced Korean Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Regional Manager Electronics Industry 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Everett Riegel Alma Leavell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 601 Isaiah Drive Severna Park, MD 21146 David L. Riegel / Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 18, 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) May Crownsville, MD 4 Donation 5 Other (Specify) MD Veterans Cemetery 2010 22. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie P.A. Severna Park Funeral Home Hwy, Severna Park, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Year Medical as a consequence of): **Examiner** DIOMYOPATHY 37em Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine 107em burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Year Day the s signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 1 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 No 1 Yes **Division of Vital** completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ASSISTED LING 2 No ٥ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D21684 tendre 5-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITCHIE HWY, PASADENA, D 8021 CYRIAC-M.D 31. Date filed (Month Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 5 **Physician** 3:17 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year 1 □ M 2 🕶 Months Days Hours Min 92 Yrs. Director 1917 214-34-6865 June 4, Hungary Usual Residence of Decedent 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examinar mant to inclined Director 1 □Yes 2 N No Anne Arundel Annapolis Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21401 USA 9000 River Crescent Drive Apt. 9213 Funeral death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Evi Armed Forces? 1 □Yes 2 ☑ No If Yes, Give Year or Dates: Black, White, etc filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 ☐No White ş Specify Specify 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Officer Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Laszlo Tehel Mary Detrick ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any Injury or other trau once. 2816 Broadview Terrace Annapolis, Maryland Maria A. Blohm /Daughter 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 5-15-2010 Edgewater, Maryland 21. Signature Juneral 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause or a ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** secuse mouths disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause or injury that in its last asserts. Due to (or as a consequence of) Examin burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760. physician The law requires that the death certificate be Physician/Medical the attending properties for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. I signed by the a d be detached for ☐Yes 2 ANo 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has bage 2 s 24a. Was ar autopsy performed certificate 1 ☐Yes 2 ☐No 1 □Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 Voo 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day, Year) Manner of Dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural ours after death. death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of W State

DHMH 17 Rev 1/2001

Registrar

MAY 172010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ear1 Francell Robertson Medical May 2010 1:12p 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🕱 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) Country Director 579-64-3983 61 May 18. 1948 Palaski Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Prince Georges Forestville 1▼ Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7503 Val Lane 20747 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married "natural", 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer / Special Law Enforcement should be filed with and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl Robertson Cleo Holmes permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robertson / Wife 7503 Val Lane Forestville, Md. Mary 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Reproval from State 4 Donation 5 Other (Specify) Maryland Veterans May 24,2010 Cheltenham, Md. 22. Name and Address of Facility
Alexander, S. Pope, P.A.
5538 Mariboro Pike/ Forestville, Md. 21. Signature of Funeral Service Licens 20747 Part . Inter the disease, complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vulmonme Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury OSTEDSARcon that initiated events Due to (or as a consequence of) resulting in death) Last use as the bunal-Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 g Unknown q Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes ရ 1 Inpatient 2 R/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 \square Pending work n 24 hours after death.

e Funeral Director: Aft bleted filled in by the fur 1 Tes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Date filed (Month,

192010

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

10-039	903	
Edwin	Mauricio	Ruiz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2015 State of Maryland / Department of Health and Mental Hygiene

		1- For State Cert	tificate of Death	Reg. N	No.	
Physici Medical Exam		Decedent's Name (First, Middle,Last)		Date of Death Month Da	y Year	Time of Death
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	May 22, 2010	4c. County of Death	0037 1115
		3400 Fort Meade Road	Laurel		Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 X M 2 F 32	st birthday) ff Under 1 Year If Under 24Hrs Months Days Hours Min		1000/YYYY) 9. Birthp Foreign 1 , 1977 Count	El Salvador
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, 1	Fown or Location		10	Od. Inside City Limits
Aaryland 28a-f show any Lat once,	į.	Maryland Montgomery	Brookeville		1	Yes 2 X No
Maryl: r 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country	?
5-0036 led within 72 hours after death with the Maryland Jygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once,	al Di	2104 Lubar Court 11. Marital Status 12. Was Decedent Ever in U.S	20833	N-	USA	<u> </u>
death w r items	uneral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American White, etc.	n Indian, Black,
safter or ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify: Sal		Specify: Whit	:e
2 hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of voluming most of working life. DO NOT use reting the control of the control		o. Kind of Business/Indu	ustry
036 ithin 7; ne. r than	Completed	2	Management		Restaurant	:
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last) Jose Ruiz		First, Middle, Maide sa Gomez	en Surname)	
212 vuld be Menta marke ic even	To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or F		City or Town, State, Zi	n Code)
MD 21 nd 2 should the lith and Mer m 27 is mar		Lorena Ruiz/Wife	2104 Lubar Court, Bro	ookeville,	MD 20833	
Ore, ges lar of Hea		1 X Burial 2 Cremation 3 Removal from State Cre		ay 28	c. Location - City or Tov	
Baltimore, sermit. Pages I ar Department of Hes important: If ite njury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	e or Heaven Cemetery	2010 Si	ilver Sprin	ng,Maryland
Depring Injury		Same & Ocean	22. Name and Address of Facility Francis J. Collins 500 University Bl	vd. W., Si	ilver Sprin	a.MD 2090:
Physician \/Medical		23a. Part I. Inter the disease, or complications that caused the leath. I failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac o	r respiratory arrest, s	hock, or heart	Approximate Interval Between Onset and
£xaminer		Immediate Cause (Final disestant anol intoxication or condition resulting in death) Due to (or as a consequence of):			-	Death
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated C				
ted d ansit	Exa	events resulting in death) Last Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit	Medical	M UNPENDED ☐ AMENDED 27 280 €	- NT -005 7/1/10 mg	-		
760, ficate be g physic the bur		IF FEMALE: 23a, 27, 28a-1, 23c, If yes, outcome of pregna		2	3d. Date of delivery	
Box 68' e death certifi the attending ed for use as	ician	past 12 months? 1 Live birth 4 Pregnant at time of deat	2 Fetal death 3 Ectopic pregna h 5 Other (Specify)	ncy	Month Day	Year
a § § a	Physician	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resi				
ires that the signed by		rait ii. Other significant conditions contributing to death but not resi	ulting in the underlying cause given in Part I.		o use contribute to the No 3 Probable	
ords, w requir. s been s should b	letec			24a. Was an		sy findings available
I Recon: The law	Completed by			autopsy performed? 1 ✓ Yes 2		pletion of cause of
of Vital Records, in Physician: The law require the this certificate has been sinneral director, page 2 should be	Be	25. Was case referred to medical examiner?	26.Place of Death (Check of	only one)		
n of Vi ding Physi After this funeral dir	٦.	1 Yes 2 No I Inpatient 2 E 27. Manner of Death 28a. Date of Injury 2		g Home 5 Resid	dence 6 🗹 Other: So	ene
ion (tendin leath.	ation	1 Natural 5 Pending 2 Accident Investigation Fd 5/22/10 F	'd 12:31 a ¹ Yes 2 No	unk	,,,,	
Division spiral or Attendir iours after death.	ertification:	3 Suicide 6 Could not be 28e. Place of Injury - At hom		28f. Location (Street or Town, State)	and Number or Rural F 3400 Fort	Route Number, City
Hospits 4 hours Funera	O	29a. Certifier 4 Continue Physics To the back (as here)				
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	for investigation, in my opinion, death occurred at	due to the cause(s) a t the time, date and p	and manner as stated. lace, and due to the ca	use(s)
110	ž	29b. Signature and title of certifier	29c. License number		. Date signed (Month,	Day, Year)
3-PEN	-	30. Name and address of person who completed cause of death (Item 2)	O.C.M.E.	Ma	ay 22, 2010	
		Margarita Korell MD. Assistant Medical Examiner		21201		
St	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature	harles			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per phys. 6904 6/11/10 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 12^{Day} Isaac Reyes Jr. 2010 7:47 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery County Washington Adventist Hospital Takoma Park if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Apr. 29, Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Country) W York City Hours 131-28-7099 73 Director New Usual Residence of Decedent or 28a-f show s notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Bowie 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 12403 Sarah Lane 20715 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2X Married ð Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Sales Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Isaac Reyes Sr. Jennie Sanchez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita L. Reyes / Wife 12403 Sarah Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Mt. Oak U.M. Cem. 05/16/2010 Mitchellville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service License 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. RENA Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine ASTINAL DNFECTION and burial-tran Due to (or as a consequence of) resulting in death) Last physician s the burial REPAIR Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death signed by the a 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à RESPIRATORY Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed MORBID OBESIT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 X No MANCER ROSTA certificate | 1 Yes 2 No 1 Yes 24 hours after deau.. 3 Funeral Director: After this certifica aleted filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No 2 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred To the Hospital or Attending 1 Natural
2 Accident
3 Suicide 5 Pending injury work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I and title of ce 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 TAKOMA PARK, MD PIOTE WYRHINSKI 7600 CARROLL ANE. 31. Date filed (Mon gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician Month William Lee 21 2010 Reed May 11:30 p. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 18806 Vandes Lane, S.W. Rawlings Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | April 30,1940 | Bloomington, MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Yrs 70 **Director** 215-36-8909 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State or items 23a or 28a-f show rust be notified at 1 ☐ Yes 2 🙀 No Director MD Allegany Rawlings 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21557 Funeral 18806 Vandes Lane, S.W. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene.
em 27 is marked other than
ther traumatic event, he Office Machine Technician Office Supply Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Leroy Reed Donnadean Ervin ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is other tra Nancy Reed/ Wife 18806 Vandes Lane, S.W. Rawlings, MD 21557 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or o once. ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 27 4 ☐ Donation 5 ☐ Other (Specify) 2010 Sunset Memorial Park Cunberland, MD 22. Name and Address of Facility Smith Funeral Home 21. Signature of Funeral Service License new 85 S. Main Street Keyser, WV Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ou5 PSM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence off executed Exami burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached f I ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 🗖 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Besidence 6 Other (Specify) Hospital: 1∐Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hours a 29a. Certifie 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hou To the Funel completely fil

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Thomas Chappell,

DHMH 17 Rev 1/2001

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912 Seton Drive

29c. License number

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Cumberland, MD

29d. Date signed (Month, Day, Year)

21502

and manner stated

M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of Lath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Catherine Doll23 2010 Routzahn May 1:05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Denton Homestead
5. Social Security Number Manor | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 26, 1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕁 F Months 216-22-8336 87 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exercitation at once. 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits Maryland Caroline Federalsburg 1X Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21632 U.S.A. 411 West Central Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 □Yes 2√2 No Specify þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Property Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles David Oland Mamie Beatrice Grubb ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8780 Marsh View Road, Easton, MD 21601 Mrs, Sherry Spencer, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date **Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery May 27, 2010 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee 22. Keeney and Basford PA Funeral Home were M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** matastatic colon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that in its and on the cause (Disease or injury that in its and on the cause of the cause Examine Due to (or as a consequence of): the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No spital or Attending Physician: Thours after death.
Ineral Director: After this certificate filled in by the funeral director, pa 1 ☐ Yes 2 🖼 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Assistes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 0005325

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Registrar

Melinda

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32) Registrar's Signature

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Pieston MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc , 5 per fh g904 6-18-10 vt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Margret Ella Smith Physician/ Month 3-20 A M Margaret 0 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington Washington County Hospital <u>Hagerstown</u> 7. Age (In vrs. last birthday If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Davs Hours Min. Country) Director MD 282-36-9156 Usual Residence of Decedent or 28a-f show 10b. County 10a. State should be filed within 72 hours after death with the Maryland 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11 West Baltimore Street Apt. 420 21740 USA or items . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jesse Childers Jennie Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5017 Norcrest Drive Columbus, Melissa King/Daughter OH 43232 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 5/25/2010 Peter Catholic Hancock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 M00260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death; shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) menths Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 🗌 Yes 2 🗌 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 No Certificate: To npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident within 24 hours after deal To the Funeral Director; Suicide 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed (Check only one 29b. Signature and title of qertifie 29d. Date signed (Month, Day, Year) MP2174 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PA i est 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 Tay May 20^{Year}0 Nola V. Stansbury 3:33 Ам Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Anne Arundel Harwood 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 □ M 212 F Hours Jan 22 Director 216-34-7059 Yrs Maryland 1933 Usual Residence of Decedent 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 X No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1255 Stonewood 21409 IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Š 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 ¥ Widowed 4 ☐ Divorced Completed Black. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 7th 0 Nursing Assistant Private Family injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Henson Christina Branford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21403permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau Phyllis Cook(Daughter) 220 A Hill top Lane Apt 102 Annapolis, 20a. Method of Disposition 20b. Maee of Disposition (Name of cemelery, crematory of other place) 20c. Location ~ City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) U.M. Church 5-17-10 Arnold, Md. 21. Signature of Funeral Service Licensee 20 Marne a Richard Facility Sons Mortuary, P.A. 821 West St. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
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| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

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Division of Vital

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day Year)

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1		4a. Facility Name (if not institution	n, give street and n				b. City, To		ocation of	Death		i i	unty of D		
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MD 21215-0036 d 2 should be filed within 72 hours after than and Mental Hygrene. n 27 is marked other than "natural", , aumatic event, the Medical Examiner.	의	19a. Informant's Name/Relations												tate, Zip Code)	
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To the within To the comple	To Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a superior one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (_			
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		30. Name and address of person	who completed car	use of de	eath (Item	23a)									
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Sta	ate	31. Date filed (Month, Day, Year)	2010 32.5		's Signatu	ire.	41								
Regist	rar	MATZY	ZUIU /	ener.	4	a. salah	A COLUMN TO THE PARTY OF								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** May 12, 2010 Stephan 6:10 AM Norma Jean /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Yea Feb. 20, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Min. Hours 1 ☐ M 2 🖫 F 68 1942 218-40-1713 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Era viner must be notified at MD Carroll Westminster 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 705 Deer Park Rd. 21157 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2Ñ No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other traumatic event. Random House Mail Clerk 18 Mother's Name (First, Middle, Maiden Surname) ELLZADETH AShET 17. Father's Name (First, Middle, Last) Albert Black Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
29 Mountain Ash Dr., Hanover, PA 17331 19a. Informant's Name/Relationship (Type. Print) Theresa Adams - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Deer Park Cemetery 5/15/2010 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Pritts Funeral Home & Chapel, P.A. 21. Signature of Funeral Service Licensee KIL 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each | | | Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of). Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical as yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent preg 3 Ectopic pregnancy Day Month in the past 12 mg Pregnant at time of death 5 Other (specify) P.O. ☐ Yes been signed by the should be detached 9 Unknown 9 Unknow contributing to death but not resulting in the underlying cause given in Part I. Part II. Other signific 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 2 🗆 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? thin 24 hours after death. the Funeral Director: After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Accident in by the 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of continer 29c. License number WIL 12 leted cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jane Porter Shanks 1831 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Carroll Hospital Center Carroll County Westminster Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Feb. 27 Min 1 M 2 81 227-54-9088 **Director** Virginia 1929 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Carroll County Maryland Westminster 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 6 10f. Zip Code Funeral items 23a 2108 Snydersburg Road 21157 United States death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or Maryland 21215-0036 hours after If Yes, Give Year or Dates white 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of the marked of permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Mary Edith Williams Frederick Porter Armentrout ____ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2108 Snydersburg Road Westminster, Maryland 21157 Meredith Hileman Shanks/husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Kirkridge Presbyterian May 17, Manchester, Maryland 4 Donation 5 Other (Specify) emeteri 22. Name and Address of Facility Fline Funeral Home Signature of Funeral Service License M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RICULAR Physician/ FIBRILLATION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dequernally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the bunal-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death detached 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ within 24 hours after death.

To the Funeral Director: After this certificate has been signe completed filled in by the funeral director, page 2 should be a ARTERY DISEASE 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 🗆 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No √ Natural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ acamma whetheren 00018 00 05-14-10 WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RCP. WESTMINST poole HITRACHEDU NAGANNA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Joan Wood Steele 08-21 AM 2010 May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County E1kton Cecil Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan. 8. 1963 1 🗆 M 2 🎾 F Months Hours 213-88-5075 47 ^c°Maryland Director Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cecil Maryland Conowingo 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Iral", or items 23a or Examiner must be Funeral 147 Christie Hill Road 21918 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify. 3 Divorced 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Shipping/Receiving Manufacturing of Health and Mental Hygie If item 27 is marked other In other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clement Steele Betty Bullock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 147 Christie Hill Road, Conowingo. Maryland 21918 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau William H. Steele, Jr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 XI Cremation 3 Removal from State Evans Eagle Crematory 05/24/10 Leola, Pennsylvania 4 Donation 5 Other (Specify) ture of Funeral Service Licens A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner week Sequentially list conditions Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury to (or as a consequence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed 1 ☐ Yes 2 ☐ No Yes 2 No Vital 25. Was case referred to medical Hospital or Attending Physician: funeral director, Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ပု 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examing and a law of missing at the state of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30. Name and addre

SATAIYTILA (
31. Date filed (Month, Day, Year)

s of person who completed &

TEEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ma v Bertram E. SCHATZ Physician/ 2010 9:07 P ^M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda 9316 Cedar Lane 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Days Hours Min. Pennsylvania 1 X 1 M 2 □ F 160-07-8295 Director 91 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🖔 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 Funeral 9316 Cedar Lane United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. 1940 'S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) WTOP-Elementary/Seconday (0-12) College (1-4 or 5+) Washington Post Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ഉ Gertrude Singer Henry Schatz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1645 Meribrook Rd., Philadelphia, PA Robin Schatz, Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of I
Important: If ite
any injury or ott
once. cometery, crematory or other place)
King David Memorial Garden 05/16/10 1 X Burial 2 Cremation 3 X Removal from State Falls Church, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liganose Torchinsky Hebrew Funeral Home 20012 254 Carroll St. NW. Washington. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final End Stage Renal Disease Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant
9 Unknown Pregnant at time of death Yes 2 No s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 育 1 🗌 Yes 2 🗆 No 3 🗆 Probably 4 ื Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work 1 ☐ Yes 2 ☐ No Acc.
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License numbe 29d. Date signed (Month. Day, Year) d title of ce 29b. Signature a ρ D 0063196 May 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew McAndrew, M.D., 1355 Piccard Drive, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Dep Registrar	partment of Health and I partificate of Death		ene2010	17158				
	Physic		1. Decedent's Name (First, Middle, Last) Jerome D. Stovall		2. Date of Death	2010 Year	3. Time of Death 6:15 p M				
,	/Medi Examii		4a. Facility Name (If not institution, give street and number) Bedford Court Nursing Home	4b. City, Town, or Location of Death		4c. County of Death					
	Funeral Director		5. Social Security Number 577-24-0569 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 89 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y) Feb. 17,	9. Birth Co.	place (State or Foreign intry) Texas				
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23e or 28e-f show entry injury or other traumatic event, the Mudical Examinar quest be trailled at ODGs.	To Be Completed by Funeral Director	10e. Street and Number 14628 Kelmscot Drive 11. Marital Status 1	Ner Spring 10f. Zip Code 20906 Was Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify: edent's Usual Occupation e kind of work done during most of work DO NOT use retired) siness Owner 18. Mother's Nam Ellen ling Address (Street and Number or Rui ale Drive, Rockvil cosition (Name of amatory or other place) n Memorial Park	pecify Yes or No- o Rican, etc.) Indicate, Middle, Mark Lawler Tal Route Number, C Ille, MD 20 Date May 20 2010 Ro	Printin Printin iden Sumame) ity or Town, State, Zi 0850 c. Location - City or Tockville, M	can Indian, etc. ite idustry g c Code) own, State aryland				
	Physician /Medical Examiner	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			isase	Approximate Interval Between Onset and Death				
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	ery Day Year				
ecords, P.	w requires that been signed by should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did tobac	co use contribute to t					
Ĭ	The ate ha	e Completed	25. Was case referred to medical			sy prior to completion of cause of					
	ng Phys fter this ineral di	on; To B	examiner? Sexaminer Pospital: I Inpatient 2 ER/Outpatient 3 DOA Other: 4 Interest only one 5 Residence 6 Other (Specify)								
2	t hours after of thours after of thours after of the thours after of the thousand the the thousand the thousa	edical Certificati	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, st building, etc. (Specify) 29a. Certifier (Check only) 29d. Certifying Physician: To the best of my knowledge, deat 2 Medical Examine. On the basis of examination and/or in	h occurred at the time, date and place	City or Town, Si	e(s) and manner as s	totad				
1	within 24 To the F complete	Medi	29b. Signature and title of certifier	vestigation, in my opinion, death occurr 29c. License number		and place, and due to					
0	20+1		30. Name and address of person with completed cause of death (Item 23a) (Type,	Prhi 3701 international	Yel Cox	17, S.S.	Md, 20106				
	Stat Registra	.e	31. Date filed Month, Day, Year) 32. Registrar's Signature 22. Registrar's Signature	es.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 William Edward Spriggs 8:45 p M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Cheverly Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month, Day, 1 M 2 D F Days Hours 1934 217-32-4384 Washington, D.C. Director 76 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Mary land Prince Georges Upper Marlboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 66 Herrington Dr. 20772 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic <u>Private</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Spriggs, Sr. Dorothy Thornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 <u>66 Herrington Dr. Upper Marlboro, Md. 20772</u> Evelyn Spriggs / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Harmony Memorial 5/11/2010 Landover, Md. 4 Donation 5 Other (Specify Signature of Funeral Service Lice 22. Name and Address of Facility Alexander S. Pope Pike/Prorestville. M 01 085 20747 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lilled in by the innertal director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 🗆 Probably 4 🗆 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Hospital: Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 125-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 3001 Hospital DR Cheverly, who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 145PM CHARLES STEWART Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S CHEVERLY PRINCE GEORGES HOSPITAL CENTER 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign If Unde 8. Date of Birth Age (In yrs. last birthday) **Funeral** Days New Orleans, LA 1 🔀 M 2 🗆 F Director 437-72-2843 63 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 X Yes 2 □ No LA New Orleans 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 928 North White Street 70119 United States Items death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 ð 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 72 hours after 1 ☐ Yes 2 💢 No Specify: Specify: Black "natural", 3 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sopervisor <u>New Orleans Parkway</u> Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic 6 Lawrence Shorty Emma Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 928 North White Street New Orleans, LA 70119 Brenda Stewart / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Spec)(y) 5/13/210 Pilgrim Baptist Ch Convent, LA 21. Signature of Funeral Service 22. Name and Address of Facility Pope Funeral Homes, P.A. ~101085 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MITMSHANC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Nona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin The law requires that the death certificate be executed as the burial-transi resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has autopsy performed? certificate 1 ☐ Yes 2 🛣 No Yes 2X No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 \(\text{Yes} Other: 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA ဍ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 XNatural 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certific 10 20055 703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 TSION BERHANE, MD.

Registrar

DHMH 17 Rev 7/2009

MAY 1 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar AMEND#13perFH,5/18/10,EMW,McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lina TURNER May 16, 6:10 A M Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 9. Birthplace (State or Foreign Country) Cuba If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, Funeral Min bc(#^{onth}28^y, Year)925 84 Director 579-38-7482 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Mantal Hygiene and the titlem 27 is marked other than "natural", or items 23a or 28a-f show and tiflet may be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director Silver Spring Montgomery Maryland 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States Funeral 20902 1601 Ladd Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Cuban white If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Francesca Shub 2 Solomon Feldmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 16920 MacDuff Avenue, Olney, MD Tayo State, Zip Code) Norman Turner, Son portant: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or of once. 1 KBurial 2 Cremation 3 X Removal from State Ohev Sholom Cemetery 05/17/2010 4 Donation 5 Other (Specify) Washington, DC Porchinskysshebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Septicemia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifie D0061937 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FOREST GLEN RD 120 -1500 ACE L Registrar's Signatu State 2010 Registrar

10-03684 John Uram

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Decedent's Name (First, Middle, Last) John Robert Uram, Jr.			For State Certificate of Death Reg. No.									To the open		
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Projector MAY 17 2010 anus S. Jacks					Registrar's Signa	ture	1 .	,						
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Amend Item 25 State of Mandand Programment Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death May 20, 2010 Physician/ Anthony Armand Vallieres 5:55p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14110 Parkvale Road Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Hours Month, Day, Year) 0 / 0 2 / 1950 Vashinaton. Director 213-56-7258 59 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Rockville 1 ☐ Yes 2 🗶 No Montgomery 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 14110 Parkvale Road 20853 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ☐ Yes 2 🛛 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates 'natural", 3 Widowed 4 Divorced Completed Caucasian event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CPA Public Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Armand Vallieres Eleanor Fay Leiter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 st ment of Health a tant: If item 27 is jury or other tra Gail Flister Vallieres-Spouse 14110 Parkvale Road, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or oth 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 05/21/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. al 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Arteriosclerosis Coronary Artery Disease Medical Due to (or as a consequence of): year Examiner than 10 Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER death certificate be executed Hyperlipidemia the burial-transi 8 Years that initiated events resulting in death) Last and Due to (or as a consequence of): nding physiciar Physician/Medical Sleep Apnea use as 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Bipolar Disorder Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Arthritis 24a Wasan Hospital or Attending Physician; The law page 2 performed? Yes 2 X No Gout certificate 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending n 24 hours after death.

e Funeral Director: After the form of the Accident Investigation 6 Y Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ompliami D0040804 May 24. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, #342, Silver Spring, Maryland 20902 Sharma. MD 31. Date filed (Month, Day, Year) Registrar's Signature State 26 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Physician/ Ruth N. Walker 2010 11:25 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Caroline County Marydel 17360 Henderson Rd. 8. Date of Birth (Month, Day, Year) Mar 29, 1922 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🕅 F Hours 213-46-7834 88 Director Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Prince George's Bowie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with United States 1700 Church Rd. 20721 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. id Mental Hygiene. marked other than "natural", or i þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3X Widowed 4 □ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental F Important: If item 27 is marked o Maude Bowen William Edward Lusby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Galicinao/Daughter 3945 Windermere Way, Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or 05/17/2010 Clinton, Maryland Resurrection Cem. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Atherosclerosis Cardio vascular disean Immediate Cause (Final Onset and Death Physician/ 5 Yrs Medical resulting in death) Due to (or as a consequence of) Examiner cancer Breast Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that the death certificate be executed that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician. The law requires the within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Records, Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☑No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058213 arhad Aunapolis Rd # 308 6 leen Dale MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12150 JAMALI MD 31. Date filed (Mor egistrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 12 2010 Edith Μ. Worthington 2239 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕇 F Months Days Hours Min. May 21, Year) 921 88 **Director** 577-44-8252 DC Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DCWashington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral be filed within 72 hours after death with 20003 129 Duddington Place SE United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. δ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Africian American 1 Yes 2 X No Specify: If Yes, Give Year or Dates uld be filed w... rd Mental Hygiene. '⊶d other than "natural: '⊷e Medical E: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) National Security Agency Government Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other item 27 is marked other other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joshua J. Worthington Mary Tolson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Womack/ Niece 127 33rd Street NE Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place). Harmony Memorial Park Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. May 24 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Landover, Maryland Sociatur, of Funeral Service Li 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Rd. 20019 NE Washington, DC 23a. Part Briter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 13ACTER COMIA Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MULTIPLE MYELOMA Sequentially list conditions, if any leading of incediat cause. Enter Underlying Cause (Disease or iinjury Examine Drin to for as a nonsecuence of or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No detached g Unknown g 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. eral Director: After this certificate has been signed ifilled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ DEMENTA 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident Investigation 24 hours after deal Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hound to the completed file Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2010 D044957 who completed use of death (Item 23a) (Type, Print) 10 7600 CARROLL 31. Date filed (Month, Day, Year) State MAY 1 8 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ 12:30 PM EDWARD J. WHEATLEY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Pay, Year) Months 213-26-7371 1 💢 M 2 🗆 F MARYLAND Yrs. Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No MARYLAND WORCESTER BERLIN 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 26 MARTINIQUE CIRCLE 21811 US 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 1 Q 5 1 — 5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 If Yes, Give 1951–57 Year or Dates 1 ☐ Yes 2 XNo Specify: WHITE 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 8 WAREHOUSEMAN GROCERY Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H မ GRETA SINGHASS should be AMOS L. WHEATLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEARLIE W. WHEATLEY/WIFE 26 MARTINIQUE CIRCLE, BERLIN, MD. 21811 Health tem 27 Page 1 and 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other pla MELSONS CREMATORY 20a. Method of Disposition 20c. Location - City or Town, State ŏ ☐ Burial 2 X Gremation 3 Removal from State 5-15-10 FRANKFORD, DELAWARE 4 Donation 5 Other 21. Signature Funeral Set ce L 22. Name and Address of Facility MELSON FUNERAL SERVICES, THATCHER STREET. FRANKFORD. DELAWARE 19945 23a. Part 1. Enter the disease, or complications to caused the death. Do not enter the mode of such as cardiac or respiratory arrest Approximate shock, or heart failure. Lis Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transit and Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the buria Completed by Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year 9 Unknown law requires that the Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Wheathey 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has 2 No 1 Yes 25. Was case referred to medical Vital 26. Place of Death (Check only one, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death of 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending Division М 1 Yes 2 No Investigation Accident filled in by the within 24 hours after deal To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1709 M Li<u>ndsay</u> Mav 010 <u>Worthington</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Medical University of Center Baltimore If Under 24 Hrs 8. Date of Birth (Month, Day, Year, Oct. 10, 1 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Hours 45^{Yrs.} Director ΝÝ 127-58-7999 1964 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MD PG Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2203 Iverson Street 20748 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces ģ 1 X Never Married 2 Married ☐ Yes 2 🙀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:Bl<u>ack</u> If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cook Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eugene Balfour Maqdalene Gordon .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 Iverson Street Temple Hills, Md. 20748 Curtis Hicks/brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/15^{Date} ō 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Important: If any injury or once. 4 Donation 5 Other (Specify) Resurrection Cemetery Clinton, Md. 22. Name and Address of Facility Hodges 21. Signature of Funeral Service Licensee & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Meningitis Medical Examiner Due to (or as a consequence of): Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate | 1 ☐ Yes 2 📉 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA Certificate: To within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check з 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1316171240

State Registrar Michael

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

St., Baltimore,

Md.

Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Green

South

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAYth 24,2010 9:10P ANNIE CECELIA YATES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES LAPLATAGENESIS LA PLATA CENTER 9. Birthplace (State or Foreign M Pountry) Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 1 Monty Day 9909 1 M 2 Tyr 100/rs. 216-22-2302 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director LA PLATA MD. CHARLES ¹X☐ Yes 2 ☐ No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 20646 U.S.A. or items 23a Funeral 1 MAGNOLIA DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify BLACK 1 ☐ Yes ※☐ No Specify: "natural", 3 X Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) CHARLES CO. Elementary/Seconday (0-12) College (1-4 or 5+) MGR. of FOOD SERVICE BOARD OF EDUC. 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARY DELLA HAWKINS AARON WHALEN permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 GARNER AVE. WALDORF, MD. 20602 BARBARA ROSIER-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ST. MARY O'CEMETERY 1X Burial 2 Cremation 3 Removal from State 6-2-10 NEWPORT, MD. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee M00479 Name and Address of Facility
AYMOND FUNERAL SERVICE
A PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one of Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Lan Medical Due to (or as a consequence of): Examiner SCLENOST Sequentially list conditions Examine cause (Disease or linjury Due to (ur as a consequence of, ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 22 No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 Wo 1 🗆 Yes 2 🗆 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 🗌 No death. Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day Year) dress of pers of death (Item, 23a) (Type 002 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Physicia	an/	1- For State Registrar 1. Decedent's Name (First, Midd			ertificate o	t Deal	rh	· <u>-</u> -	2. Date of D Month May 24,	Reg. No eath Day	D	546	Time of Death
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1		2930 Bethany Lane	on, give street and no	iniber)		•	tt City	Location of Book			Howard		
Funeral Director		5. Social Security Number 218-96-8085	6. Sex	7. Age (In yrs	s. last birthday)	Mont	er 1 Year			•	7,1965		olace (State or Foreign try) timore, MD
		Usual Residence of Decedent	· (A)										
ow any		10a. State 10b. County			ity, Town or Loca								0d. Inside City Limits 1 Yes 2 XNo
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	MD Howal 10e. Street and Number 2930 Bethany		ET	licott (10f. Zig 21	Code 042				itizen of What	Countr	
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after death all', or iter	by Funeral	Never Married 2 M Widowed 4 Div	Armed F 1 Yes Vorced If Yes, Give Yes or Dates:	2 X No	1	Yes 2	X No	specify:			Specify:	Whit	
6 n 72 hours an "natur ical Exami	Completed t	15. Decedent's Education (Spe Elementary/Secondary (0-12)				nost of wo	rking life.	ion (Give kind of DO NOT use rei tant			Kind of Busin		•
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle Bernard A. Ze	•			18.Mother's Name (First, Middle, Maiden Surname) Charlotte Keyes							
MD 212. nd 2 should be uth and Menta in 27 is marked aumatic even	To Be	19a. Informant's Name/Relations Mr. & Mrs. Ber	ship (Type, Print) Do		19b. Mailin	g Address	(Stree	t and Number or	Rural Route N	lumber,	City or Town,	State, Z 1048	(ip Code)
iore, N ggs 1 and 2 tt of Health i: If item 3		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal fr	201	b. Place of Dispo	sition (Nather place	ne of cen	netery, 5, Inc. 5	Date /26/20		Location - C Hampst		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service			22.	Name and	Address Va s h	of Facility Pri	tts Fu	nera stmi	l Home nster,	& (Thapel D 21157
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that c	aused the dea	ath. Do not enter	the mode	of dying,	such as cardiac	or respiratory	arrest, sl	hock, or heart		Approximate Interval Between Onset and
Examiner	9	Immediate Cause (Final disease or condition resulting in death)	7700000			ascu	lar (disease				-	Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a	a consequence	e of):								
cuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence	e of):								
e execute cian and irial - tran	dical	XUNPENDED	AMENDED 23a.	PII,27	per ME	g904	6/8	/10 TT					
Division of Vital Records, P.O. Box 68760, vitin 16 death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	sician/Medica	IF FEMALE: 23b. Was decedent pregnant in to past 12 months?	he 23c. if yes,	outcome or pr	egnancy 2 Fe	etal death	3 [Ectopic pregn	ancy	2	3d. Date of de Month	livery Da	y Year
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on of Vit ending Physic ath. or: After this of	tion: T	27. Mapper of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred											
Divisi ital or Att urs after de rral Direct	Certification:	3 Suicide 6 Cou	estigation 28e. Place ermined (Specify)		t home, farm, stre	eet, factory	, office b	uilding, etc.		n (Street n, State)	and Number	or Rura	Route Number, City
Divisior To the Hospital or Attend within 24 hours and or feet death To the Funeral Director; completely filled in by the	Medical C		thysician: To the beaminer: On the basis and manners	of examination									
E \$ E 8	Me	29b. Signature and title of certifi				29	c. License	e number			I. Date signed ay 25, 2010		n, Day, Year)
NOVA		30. Name and address of person				11 Pon-			MD 24204	IVIC			
2	tate	Pamela E. Southall, N 31. Date filed (Month, Day, Year)	122.46	Medical Ex egistrar's Sign	oturo		otreet	t, Baltimore,	IVID Z IZUT				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ May 13, 2010 10:00 pM Richard Henry Zeh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 3222 Medway Street Wheaton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral Country) D.C. 1 M 2 □ F Months Days Hours Min Jan. Bay, ^{Year)}932 579-40-4007 78 Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10d. Inside City Limits or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No Wheaton Maryland Montgomery 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 20902 USA 3222 Medway Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc.
White 1 Never Married 2 Married \$ 1 ☐ Yes 2 No If Yes, Give Year or Dates. within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Partsman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o Mary Louise Spaulding William Henry Zeh pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3222 Medway Street, Wheaton, MD 20902 19a. Informant's Name/Relationship (Type, Print) Beverly K. Zeh/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May Date 18, cemetery, crematory or other place)
Fort Lincoln Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service License MD 20901 23a. Part 1. Exper the disease, or complications that caused the death: Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death 2 years Immediate Cause (Final Physician/ Metastatic Colorectal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ll years Colorectal Cancer Sequentially list conditions, Due to for as a consequence of Examine if my leading to immed cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical certificate be Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? The law requires that the death ō Month Year Day Pregnant at time of death detached 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Degenerative Arthritis 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed? Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification open partial director, and the funeral director, the funeral director is the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 🔽 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending work 1 Yes 2 No М 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Burrell, MD 2730 University Blvd., West, Wheaton, MD 20902

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2010

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Registrar's Signature

Saltimore, Maryland 21215-0036 **Physician** /Medical Examiner Examine and Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical been signed by the attendin should be detached for use þ Be ပို Certification: r death. neral Director: A Medical State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 5:13 May Elizabeth Allik 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balto, Manor Care Ruxton Towson If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F November 15,1915 Maryland Director 94 219-07-1750 Usual Residence of Decedent iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It filem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Balto. Md. 1 ☐ Yes 2√ No Director Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21286 500 Virginia Avenue Apt. 1204 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 22 No If Yes, GiveX Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Gajewski Joseph Rutkowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: if item 27 is any injury or other tran Apt. 809 Towson, Md. 21286 500 Virginia DTR. Avenue Mary E. Allik 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-4-2010 Balto. Md. Gardens of Faith 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home Nottingham, Md.21236 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementic days disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 □ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 2 🗌 No 1 ☐ Yes 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carmela K. Adornato Mayonth 30 Day 2010 Year 1: 45 A_M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2607 Edgewood Avenue Parkville Baltimore Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 170–26–7478 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Min. Months Hours Pefffsylvania Director Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. Count 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Parkville 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 109, Citizen of What Country? Funeral 2607 Edgewood Avenue 21234 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. white Armed Forces ō Š 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☒No If Yes, Give 1 ☐ Yes 2 No Specify: しなっかん(な、 ガdoこんな+ Baltimore, Maryland 21215-003 "natural" Completed Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 75 nent of Health and Mental Hygiene. ant; If item 27 is marked other than Raltimore County School System Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Catherine L. Romeo Samuel Adornato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue-Indiana, Pennsylvania 15701 Rose Novak-sister 108 Greendale 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of F Important; If ite any injury or ot once, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Fureral Charel and Cremation Services Belair June 1,2010 Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 Fadd L. ME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CANCEK disease or condition resulting in death) ON Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Jause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death the 9 Unknown 9 Unknown s been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available After this certificate has prior to completion of cause of death? autopsy performe 1 Yes 2 No Yes 2 **Director**: After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral E Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e and title of certifi llissa 30. Name and address of person of death (Item 23a) (Type, Print) HARLES ST. BALTIMORE, MD 21204 KUSSA DI Web 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of Manyland, 17pg FFH, 6905 to 7/18/2010, WS Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Arnold 10:35 AM Lvvina 06 01 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Community Certer Baltmore VA Loch Raven Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In y s. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1**™**M 2□F Months Days Hours 216 07 822 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore White Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19708 Trunk Road 21161 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify. White 3 ☑Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Diver

Navy

Driver 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irving Arnold Bertha Boughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Ford /daughter 19708 Trunk Road White Hall MD 21161 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Holly Hill Cemetery 6/4/10 1 Spurial 2 Cremation 3 Removal from State 4 Openition 5 Other (Specify) Baltimore MD 5 Other (Specify) 22. Name and Address of Facility 300 MACE Ave. 21. Sign Baltimore Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzhemer's Dementia 8 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant al time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funeral Director: A Fo the Hospital

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Be Completed by Physician/Medical Examiner

physician and s the burial-transit

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signed by the at d be detached for

Funeral

Director

"natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a eny injury or other traumatic event, the Medical Examiner must once.

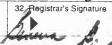
Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

To the Funeral Director: After this certific completely filled in by the funeral director.

Medical Certification: To

State Registrar 31. Date filed (Mörith, Day, Year)



cause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P / Im OTH 520 2010 Medical Facility Name (if not institution, give street and number) Examiner City. Town, or Location of Death 4c. County of Death timore Medical +mDRel Social Security Number 7. Age (In vrs. last birthdav If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. 219-50-1549 63 Country) Director 3-16-1947 MARYLAND Usual Residence of Decedent show 10a, State filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f MD. N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (by Funeral 1603 GWYNNS FALLS PKWY tems 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married Black, White, etc. þ Saltimore, Maryland 21215-0036 1 Yes 2 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Divorced Completed Specify: BLACK event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working id Mental Hygiene. marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) **MECHANIC** AUTO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FREDDIE ARCHER PAULINE RAWLINGS and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sment of Health ann: If item 27 i BEVERLY ARCHER (SISTER) 1603 GWYNNS PKWY. BALTIMORE. FALLS MARYLAND 21217 20a. Method of Disposition 1 Burial 2 Cre 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o nation 3 Removal from State GARRISON FOREST VETERANS 4 Donation 5 Other (Specify) 5-4-2010 OWINGS MILLS, MARYLAND HIBNER 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. MAHTAMOF D. 1721-27 N. MONROE ST. BALTIMOME, MARYLAND 21217 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a, Part Approximate Interval Between Onset and Death Immed te Cause (Final diseas For condition Physician Stroke diseas or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): Examir nding physician and use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death ed by the a detached f Unknown Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? autopsy certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ပ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🗌 Yes hours after death 2 🗌 No Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопріете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 000

State
Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) Year 35 AM Physician Mar Gare + M.

4a. Facility Name (If not institution, give street and number) 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) JULY 31 1 5. Social Security Number . Age (In yrs. last birthday, **Funeral** 1922 MARYLAND 217-26-0029 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a. State 10b. County 1XXYes 2 □ No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f, Zip-Code 23a or with must be 21213 U.S.A. 3309 LYNDALE AVENUE Funeral death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite the Medical Examiner 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 🖔 o Specify Specify: **BLACK** þ 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A HOUSEWIFE <u>12th grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JULIA GROSS GEORGE GROSS ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. 3600 Southern AVe., Baltimore, Md., 21214 Damon W. Bowen/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON NATIONAL CEM. 06-02-2010 BALTIMORE, MARYLAND 21. Signature of Fineral Se WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic obstructive pulmonary discase /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) physician and Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 2 No 1 Yes Completed Heart failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No DIABERS MILITUS page 2 2 🗌 No 1 ☐ Yes 1 TYes certificate 26. Place of Death (Check only one) Hospital or At ending Physician: 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes Certification: To 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 V Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident Director: A Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours after
To the Funeral Directory
Completely filled in by after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RE5-000

DHMH 17 Rev 1/2001

State

Registrar

May 27, 2010

600 North Wolfe St, Baltimore, MD, 21287

H.D.

32. Registrar's Signature

coards

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rina Khatri, M.D. 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day June 2010 ear Helen G. Bubeck 2 1:15 а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Sunrise Assisted Living Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 X Months Days Hours (Month, Day, Year) **Director** 114-26-9563 100 1909 Usual Residence of Decedent 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Tes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6500 Freetown Rd. 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bank Officer Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked of ၉ Waters Catherine Rooney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Charles Bubeck - son 1188 N. Tamiami Trail #505, Sarasota, FL 34236 Page 1 and 2 other Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Crematory June 2, 2010 Hanover, MD M01411 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 40 F 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the dis lase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hi Immediate Cause (Final Onset and Death Physician/ (0000) disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exhabitis are death.
Funeral Director: After this certificate has been signed by the attending physician and ited filled in by the funeral director, page 2 should be detached for use as the burial-transit and filled by the funeral director, page 2 should be detached for use as the burial-transit. Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🗽 No Dav Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No М 1 Tes 2 Accident 3 Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 bours
To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifier MD Name and address of person who completed cause of death (Item 83a) (Type, Print) 0 Lavue 97115 31. Date filed (Month, Day, Year) 32. Registrates Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 034 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospita Sama vitan OVR If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number (Month, Day, Year 1 M 2 - F Months Hours Country) Director 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Fealth and Mental Hygiene. Important: If tiers 275 is marked other than "natural", or items 23a or 28a-f sho any injury or or lest teamait event, the Medical Examiner must be notified at any injury or or lest teamait event, the Medical Examiner must be notified at Director 05/30/10 1 Nes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21206 Hed State 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto chani 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Summer 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore 2010 vena tou 22. Name and Address of 21. Signature of Funeral Service Licensee 70 2/22 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arrhy thmia disease or condition Medical resulting in death) Due to (or as a/consequence of): Examiner Terminal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last signed by the attending physician be detached for use as the buria Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Tetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Tonknown within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? ☐ Yes 2 ☐ No To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No. 1 Natural 5 Pending Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Escritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Kathleen L. Shottermin 000626 30,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ock Raven Bld Belto, mo 21239 5601 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore.

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charlotte Elnora Bowers 3:20 A M 2010° Jwne Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Hospice If Under 1 Year If Under 24 Hrs.

Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 Months July 7, 1923 216-12-3569 Maryland 86 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD Baltimore Parkville 1 🗌 Yes 2 🗓 No 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be. Funeral 9603 10th Avenue 21234 U.S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛛 No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) At Home Homemaker 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ernest Wessel Gladys Sprinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9603 10th Avenue, Parkville, MD 21234 Albert Bowers/ Husband Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of June Date Gargeris Of Faith 1 X Burial 2 Cremation 3 Removal from State 201ŏ Rosedale, Maryland Donation 5 Other (Specify) Cemetery of Funeral Service Lice 22. Name and Address of Facility Chapel & Cremetica Services 8800 Harford Rd. Parkville, MD 21234 23a. Fart 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASPIRATION PNEUMONIA Medical resulting in death) Medical Examiner Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?
Yes 2X No has Division of Vital To the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 🗌 Yes 2 X No ER/Outpatient 3 DOA ဂ 1 Inpatient 2 within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 2 🗆 No Accident Investigation npleted filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

6.

30. Name and add

JACKIE

31. Date filed (Month, Day, Year)

JONES.

CRNP

2010

JUNE

BOWER

CHARLOTTE

2300 DULANEY VALLEY RD.

MD 21093

son who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}201<u>0</u> June Physician/ 6:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ellicott City Howard = Ellicott City Rehab. Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F July 12,1925 Argentina **Director** 216-52-9218 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland by Funeral Director MD Howard Woodbine 1 Tyes 2 TyNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15532 Bushy Tail 21797 Run United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1945—
If Yes, Give 1040 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Argentinian White 3 X Widowed 4 □ Divorced 1949 Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Master Tailor Garment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jacob Blum Rosa Goldstein other traumatic 1 and 2 should b of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15532 Bushy Tail Run, Woodbine MD 21797 Damian D. Blum-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ō Atlantic Cemetery June 3,2010 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. 21. Signalule of Funeral Vice Liceviee 1328 Sulphur Spring Road Arbutus MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final avello Vastalar Physician/ 10 SCITIOLIC disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 No this certificate has been signed by the ral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires the Within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29 c. License number 29d. Date signed (Month, Day, Year) 30641 Back River Neck Road Baltimy MD 2122 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramch Sabapa M. 201-109

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrate Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $28^{\;\text{Day}}$ Physician/ Maynth Murray Maynadier Clark, Jr 20 TO 1:34 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1601 Grafton Shop Road Forest Hill Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number 6. Sex 1 🏝 M 2 🗆 F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Feb. 29, 1932 Mary land 212-38-8358 78 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director notified Forest Hill Harford 1 🗆 Yes 2 🖂 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertalt Hygiene.

Department of Health and Mertalt Hygiene.

The most and the marked other than "natural", or items 23a on my injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be Funeral 21050 1601 Grafton Shop Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 ☑ Yes 2 ☐ No Black, White, etc Ş 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Farming Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jane West ည Murray Maynadier Clark, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1601 Grafton Shop Road—Forest Hill, Maryland 21050 Ellen Jane Regner-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Evans Funerally Charles and Cremation Services Belair 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State May 30,2010 Forest Hill, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
Newport Drive-Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee ange of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by End Stage Renal Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) ပ္ 1 Yes 2 📉 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 💢 Natural 5 Pending 2 No 1 Yes Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56508 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XIANG LONG 3900 Loch Raven Blvd, Baltimore Maryland 21218

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Year Lawrence Delano Creek 3210PM 010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Seasons Hospice Birthplace (State or Foreign Country)
 MD . Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 1X M 2 □ F (Month, Day Year) Director 219-38-2567 66 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "not man injury or other transmit 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Gwynn Oak Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21207 USA 3714 Patterson Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: African-American 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Saks 5th Avenue Trucker Driver 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ella Mae Lewis Charles Creek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3714 Patterson Avenue, Gwynn Oak, MD 21207 19a. Informant's Name/Relationship (Type, Print) Codaries Creek/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GarrisonForest Veterens 6-8-2010 Owings Mills, MD 22. Name and Address of Facility Wile Funeral Rome F.A. of Baltimore Co. 21. Signature of Funeral Service License 9200 Liberty Road, Randallstown, MD 21133 23a. Par 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) month Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or impury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed ils certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) The FT Hospite Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA : After this e 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 5 Pending Natural n 24 hours are: he Funeral Director: Aft 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 974 Auchba 8/100/ 2106/

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Reg

10-04139 Damon Chase Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mon Cha	ase		State 1- For State Registrar	of Maryland	•	artment of rtificate of		and	Mental	Hygiene	Reg. N	201	0 17193
Phy edical E	ysicia xami	an/	Decedent's Name (First, Middle,Las Damon T							2. Date of Month May 30			3. Time of Death 2334 hrs
			4a. Facility Name (if not institution, giv University Hospital	e street and number)			b. City, Too Baltimo		ocation of De	eath		4c. County of D	
Fun Dire	eral		5. Social Security Number 6. Security Number 1\overline{\text{X}}	9X 7. Ag		ast birthday) 30 Yrs	If Under Months	1 Year Days	If Under 24 Hours	VE.	of Birth (MI 16–19	M/DD/YYYY) 9	B. Birthplace (State or Foreig Country)
	w any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Locati							10d. Inside City Limits 1 X Yes 2 No
e Maryland	or 28a-f she	Director	MD n/a 10e. Street and Number 2101 Hollins Str	et		Balt	10f. Zip C		 1223		10g. C	itizen of What	Country?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene.	tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Armed Forces?	2. Was Decedent Ever in U.S. Armed Forces? If			nt of Hispanic Origin? (Specify Yes or No- r Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.	
ours after de	itural", or	ģ	3 Widowed 4 Divorced 15. Decedent's Education (Specify or	If Yes, Give Year or Dates:	No npleted)	1 16a. Deceden	t's Usual Oc		n (Give kind		16b	Specify:	African-American ess/Industry
1036 vithin 72 ho ene.	er than "na Medical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or t	5+)	,	st of workin	ploye				Entrepr	eneur
21215-0036 and be filed within 7 Mental Hygiene.	Important: If item 27 is marked other th injury or other traumatic event, the Med	Be	17. Father's Name (First, Middle, Last) Jeffrey Chase			Laon Mars			Ang	ela Dry			
MD 2 nd 2 shoul lith and M	n 27 is m umatic	19a. Informant's Name/Relationship (Type, Print) Tarsha McClamy/ Fiance' 19b. Mailing Address (Street and Mailing Address) 2101 Hollins Street						et, Ba		re, MD 21223			
Baltimore, bermit. Pages 1 and Department of Heal	nt: If iten other tra		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from Sta	ite (Place of Disposicrematory or other	er place)		.	Date -7-2010		Location - Cit	•
Baltir permit. F Departme	Importa injury or	,	4 Donation 5 Other Specify: 21: Signature of Funeral Service Licen		Ili	22. N	ame and Ad	dress o	f Facility		unera	1 Hame P	.A. of Balto. Co
Physic /Med Exam	lical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea Immediate Cause (Final disease a.				e mode of o	dying, su	uch as cardia	c or respiratory	arrest, sl	hock, or heart	Approximate Interval Between Onset and Death
LXaiii	mei		or condition resulting in death) Sequentially list conditions, b.	Due to (or as a conse	quence o	f):							
	ii.	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse									
O, e be executed	ysician and burial - transit	dical E	d. UNPENDED	AMENDED									
Box 68760, death certificate be	attending physici for use as the buri	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant at		2 Fet	al death ier (Specify		Ectopic pre	gnancy	23	3d. Date of del Month	ivery Day Year
P.O. B	by the	by Phy	Part II. Other significant conditions		but not re	esulting in the u	nderlying ca	ause give	en in Part I.				e to the cause of death? Probably 4 Unknown
cords,	ate has been signed tage 2 should be deta	Completed								24a. V		24b. Wer	e autopsy findings available to completion of cause of
Vital F	this certificate il director, page	To Be C	1 Yes 2 No	lospital: 1 Inpatie	nt 2 🗸	ER/Outpatient	3 DDA	Ot		sing Home 5		lence 6 C	Other:
sion of trending P death.	ctor: After y the funeral	1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Day, Y May 30, 2010	ear)	28b. Time of Ir 0000 hrs	1	Yes	at Work? s 2 ✓ No	Subject v	vas sho		
Division To the Hospital or Attendii within 24 hours after death.	To the Funeral Director: completely filled in by the	Certification	3 Suicide 6 Could not determined 4 1 Homicide Certifier 1 Certifying Physicia	(Specify) Loc	al Stree	et				or Tow Pulaski Hi	n, State) ghway ai	nd Hollins St	r Rural Route Number, City reet, Baltimore, MD
Fo the Ho within 24	To the Fur	Medical	(Check only	an: To the best of myOn the basis of exarand manner stated.		-							
	- 5	W	29b. Signature and title of certifier	thed, Dr				icense r).C.M.				. Date signed ny 31, 2010	(Month, Day, Year)
			30. Name and address of person who of Pamela E. Southall, MD	Assistant Medi			Penn S	treet, l	Baltimore	, MD 21201			
В	St eaist	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signatu	ire La	Mad						

ORIĞINAL

OCME

DHMH 17 Rev 1/2001 OCME 2006

10-03534					
Daniel Chambers					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death		Reg	g. No.					
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death				
Medical Exami	ner	DANTEL CHAMBERS	wn, or Location of Deat	May 6, 201	4c. County of D	1515 hrs				
		4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center Chevel		n	Prince Geo					
Funeral			ocial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9.							
Director		579-96-3035 1X M 2 F 33 Yrs. Months	Days Hours Mir	_		WASHINGTON				
		Usual Residence of Decedent		1 ' '						
* any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits				
daryland 28s-f show any Lat once.	Ď	DC WASHINGTON		· · · · · · · · · · · · · · · · · · ·		1 X Yes 2 No				
r 28a	Director	10e. Street and Number 10f. Zip C 1027 46th St., NE 20	00de 0019		g. Citizen of What 0					
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	밀		of Hispanic Origin? (S			mencan Indian, Black,				
eath w items	ner	1 Never Married 2 Married Armed Forces? If Yes, specify	Cuban, Mexican, Puerto		White, et	c.				
5 . L	Ę,	1 Yes 2 X No 3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2	No specify:		Specify: B	LACK				
ours a	od be	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual O	ccupation (Give kind of ng life. DO NOT use ret		16b. Kind of Busine	ess/Industry				
36 n 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			DDTILL					
withi giene.	E	12th L/	ABORER 18 Mother's Name	e (First, Middle, M	PRIVAT	<u> </u>				
21215-0036 uld be filed within 72 hours afth Mental Hygiene. marked other than "natural" c event, the Medical Examine	Bec	UNKNOWN	MURIEL	СНАМВ	•					
T 29 # 5	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address				tate, Zip Code)				
and 2 shoul fealth and N tem 27 is n traumatic		MURIEL CHAMBERS/MOTHER 1027 46th 20a. Method of Disposition (Name	n St., N.	E. WASH	IINGTON,	DC 20019				
ore, N s 1 and 3 of Health If item		20a. Method of Disposition 20b. Place of Disposition (Name 1 Burial 2 K Cremation 3 Removal from State crematory or other place)	of cemetery,	Date	20c. Location - City	y or Town, State				
Page ment or oth			REM. 5	/18/10	BELTSV	ILLE, MD				
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traur	- 1									
Physician	\dashv	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of	ARYLAND A	VE.,NE or respiratory arres	wash.,	Approximate Interval				
/Medical		failure. List only one cause on each line. Between Onset and								
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
7 3	_	Sequentially list conditions, b								
, j.,	Examine	if any, leading to immediate cause. Enter Underlying Cause								
₹	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
to, e be executed ysician and burial - transit		d. X UNPENDED AMENDER 7 200/ 6/7/10								
760, Icate be ex physician the burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	_TT		23d. Date of deliv	, , , , , , , , , , , , , , , , , , ,				
		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death	3 Ectopic pregna	ancy	Month	Day Year				
Box 687 death certific the attending of for use as the	sician	4 Pregnant at time of death 5 Other (Specify g Unknown	1)							
O. Bo; that the death ned by the att detached for	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying co	ause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?				
E 8 20 8	ā			1 Yes	2 No 3 F	Probably 4 🗸 Unknown				
Division of Vital Records, P tal or Attending Physician: The law requires t rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be d	Completed			24a. Was ar		autopsy findings available				
COI ne law te has ge 2 sl	m d			autopsy perform	ned? death					
/ital Rec ysician: The l his certificate b director, page		25. Was case referred to medical 26.	Place of Death (Check		INO I V	Yes 2 No				
ion of Vital trending Physician: teath. tor: After this certifi the funeral director,	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO/	Other Nursin	ng Home 5 R	esidence 6 Ot	ther:				
Division of 'pital or Attending Phous after death. eral Director: After t		27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day, Year)	c. Injury at Work?	28d. Describe ho	ow injury occurred					
ivision or Attend after death. Director: I in by the f	Certification:	2 Accident Investigation	Yes 2 No							
Jivis alter Direction	ij	3 Suicide 6 Could not be determined (Specific)	ffice building, etc.	28f. Location (Str or Town, Sta		Rural Route Number, City				
Cospita hours uneral	18. 20 a little 19. Confidence									
Divis To the Hospital or Al within 24 hours after To the Funeral Direc completely filled in by	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
To ron	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year									
		IM Co	D.C.M.E.		May 8, 2010					
d	+	30. Name and address of person who completed cause of death (Item 23a)								
U			eet, Baltimore, M	D 21201						
	ate rar	31. Date filed (Month, Day Year) 32. Registrar's Signature			OCME					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2010 11:27pm 31 Madalena Ρ. Citroni May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Oak Crest Care Center Parkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 5, Birthplace (State or Foreign Country) Social Security Number 214-18-2903 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 95 Yrs. MD Director Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or Items 23a or 28a-f sho or other traumatic event, the Medical Examinatings to retified at 1 ☐ Yes 2√2 No Director MD Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8834 Walter Blvd. 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own Home 8th and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent Petrecca Antoni Ficca ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 31/2010 Frank Rosenthal 598 Laguna Royale Blvd. Naples FL 34119 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 6/5/10 4 ☐ Donation 5 ☐ Other (Specify) Rossville MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused that eath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ardionyogat **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria P.O. Box 68760 Physician/Medical RONI 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by a No 3 Probably 4 Unknown NADALENA P. (Division of Vital Records 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed No 2 🗀 No 1 ☐ Yes 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes P☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After to 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 N.P. and manner stated.

State Registrar 29b. Signature and title of certifier

icheelle 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

R171944

CRNP MSN 8800 Walther Blvd, Parkville MD 21234

29d. Date signed (Month, Day, Year)

10-03925	
Richard Callis	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Callis		- For State Registrar	Sta	ite of Maryla		partment o Se <i>rtificate</i> o			Mental F		eg. No.	010	17196
Physician/ Medical Examine	/	Decedent's Name (I	First, Middle	•	Beniam	in Calli	.s			2. Date of Dea Month May 22, 2	Day	Year	3. Time of Death 1731 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore						h	4c. Co	unty of Death				
Funeral Director	5	5. Social Security Num 218 78 47	777	5. Sex 1 X M 2 F	7. Age (In yr 49	s. last birthday) Yr	Month	er 1 Year is Days	If Under 24Hr Hours Mir	_		Foreig	thplace (State or in untrMaryland
nd show any SE.	1	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore Baltimore								1.1		10d. Inside City Limits 1 Yes 2 X No	
the Maryland n or 28a-f sh tifted at one Director		10e. Street and Number 305 Clyde		ue			10f. Zip	Code 21227		1		of What Cour	ntry?
Baltimore, MD 21215-0036 Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1	11. Marital Status 1 X Never Married 3 Widowed	2 Mar	12. Was Dec	orces?	lf '	as Decede Yes, speci	nt of Hispa	Mexican, Puerto	pecify Yes or No pecify Yes or No perior Rican, etc.)	14.	Race - Ameri White, etc.	can Indian, Black,
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exami Completed It		15. Decedent's Educ Elementary/Second 12th	dary (0-12)	College (1		during r		king life. D	n (Give kind of O NOT use re	tired)		of Business/I	
MD 21215-0036 and 2 should be filed within 7 d th and Mental Hygiene. n 27 is marked other than aumatic event, the Medica To Be Comple	3L	 Father's Name (Fire of the second of the seco		Otis Le	eonard	Callis	na Address		E1i	e (First, Middle, I zabeth 1 Rural Route Nun	Myers	<u> </u>	Zin Code)
and 2 shou (ealth and N tem 27 is n traumatic	L	Barbara 1	Luber		20	4826	Orvi]	le A	venue		more,		and 21205
Baltimore, permit. Pages 1 as Department of He, Important: If ite	L	Burial 2 X Donation 5 1. Sign fre d Funer	Other Spe	cify:		crematory or o	remat	ory					Maryland
Physician		23a. Part I. Enter the o	disease, or o	omplications that da	eused the dea	40	JOI K	itchi	e Highv		imore	, Mary	Land 21225 Approximate Interval
Me dical Examiner		failure. List only a Immediate Cause (Fin or condition resulting i	nal disease	n each line. a. <u>Cardia</u> Due to (or as a			(medi	cal h	istory	of dial	etes)		Between Onset and Death
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to, e be executed system and burial - transit ledical Exa	-	events resulting in dea	ath) Last	d									
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D. Box 6876 the death certificate by the attending phy bothed for use as the by		past 12 months?		4 Pregna	ant at time of	death	etal death ther (Spec	_	Ectopic pregna		Mor	ntn u	ay Year
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Division of Vital Records, P.O. tal a Atending Physician: The law requires that the sa er ceath. To livector: After this certificate has been signed by led n by the funeral director, page 2 should be detach ertification: To Be Completed by P										24a. Was autop perfor 1 Yes	rmed?		copsy findings available completion of cause of S
Vital ysician: ysician: his certif director, o Be (25. Was case referred examiner? 1 ✓ Yes 2	I to medical	Hospital: 1 Ir	npatient 2	✓ ER/Outpatien		100	Death (Check		Residence	6 Other	
on of \ ending Phy ath. or: After tt he funeral of	12	27. Manner of Death 1 Natural 5	Pendin	ng	of Injury Day,Year)	28b. Time of	Injury 2	8c. Injury a	at Work?	28d. Describe	now injury o	ccurred	
23d. Date of delive Month 23d. Date of death 23d								lumber or Ru	ral Route Number, City				
								and due to the	cause(s)				
	2	9b. Signature and title	e of certifier	e Shee	1		290	O.C.M.			29d. Date May 23		th, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201													
State		1. Date filed (Month, I	Day Year)	Annua 32. Reg	gistar's Sig	parker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Gertrude Cecilia 29 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 4130 Maple Avenue Halethorpe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number **Funeral** Days 1 □ M 2 X F Hours 100 Yrs. 143 14 3567 11/06/1909 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Iteme 23e or 28e-1 show any injury or other treumatic event, the Mardical Exemples. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h Counts 1 Yes 2 No Baltimore Halethorpe Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 4130 Maple Avenue U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 A No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MSW Religious Sister 5+ years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Andrew Coffey Jane Winifred Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Mary Becker Baltimore, Maryland 21227 4100 Maple Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition New Cathedral Cemetery 06/02/2010 Baltimore, Maryland 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Liv 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Que to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Due to (Due to (or as a consequence of): attending physician Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Year Month Day in the past 12 menths? 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 esidence 6 Other (Specify) 2 10 1 🗌 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: within 24 hours after death.
To the Funerel Director: After this certifica within 24 hours a To the Funerei L

State

Medical

31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stmar tIMMO 32. Registrar's Signature

🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ORIGINAL

29d. Date signed (Month, Day, Year)

RR BUH MO 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Le	egible.	1 -7 1
State of Maryland / Department of Health and Mental Hygiene	6010	171

		1- For State Cell Registrar	rtificate of Death	Reg	i. No. 3. Time of Death				
Physici									
dical Exami	iner	Davon Dorsey 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	May 29, 20	10 0425 hrs 4c. County of Death				
		Johns Hopkins Hospital	Baltimore		N/A				
Funeral Director		5. Social Security Number 220-33-4364 6. Sex 7. Age (In yrs. I		8. Date of Birth 11/27	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)				
, a		Usual Residence of Decedent 10a. State 10b. County 10c. City,	, Town or Location		10d. Inside City Limits				
Maryland 28a-f show any 1 at once.	or		timore		1 Yes 2 No				
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Director	3135 E. Baltimore St.	10f. Zip Code 21224		g. Citizen of What Country? JSA				
P 5 E	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc. African				
ırs afte ural", miner	by	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify:	of work done	Specify: American 16b. Kind of Business/Industry				
11215-0036 Id be filed within 72 hours after Aental Hygiene. aarked other than "natural", event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2	during most of working life. DO NOT use in Student	retired)	High School				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be Cor	17. Father's Name (First, Middle, Last) Rudolph Weeks	_	me (First, Middle, Ma a Terry	aiden Surname)				
MD 212 rd 2 should b alth and Ment m 27 is mark	To E	m							
imore, MD 2 Pages 1 and 2 shou nent of Health and N iant: If item 27 is n or other traumatic		1 X Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place) Carmel Cem.	Date 7 / 1 0	20c. Location - City or Town, State Balt., MD				
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation & Other Specific 21. Signature of Funeral Service Licensee	22. Name and Address of FacilityHa 5126 Belair Rd	ri P. Cl	Lose F.Svs,PA 4D 21206-5105				
Physician		23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	Do not enter the mode of dying, such as cardia	c or respiratory arres	it, shock, or heart Approximate Interval Between Onset and				
/Medical Examiner		Immediate Cause (Final disease a. Gunshot wound to the I			Death				
		or condition resulting in death) Due to (or as a consequence of	of):						
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.							
uted id ansit									
760,	Medical	UNPENDED AMENDED							
760, ficate be g physicist the buri	_	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of preg		nancy	23d. Date of delivery Month Day Year				
hat the death certificated by the attending detached for use as 1	Physician	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown							
P.O. B es that the di gned by the e detached		Part II. Other significant conditions contributing to death but not n	resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?				
ords, P.C w requires that is been signed to should be deta	ed by			- 1 Yes	2 V No 3 Probably 4 Unknown 24b. Were autopsy findings available				
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ital sician: s certi irector	æ	25. Was case referred to medical examiner?	26.Place of Death (Che ER/Outpatient 3 DOA Other Nu		esidence 6 Other:				
of Vital Records, ing Physician: The law require. After this certificate has been si funeral director, page 2 should b	٦: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe ho					
ion tendin leath. tor: A	atior	1 Natural 5 Pending May 29, 2010 2 Accident Investigation	0116 hrs 1 Yes 2 No	Subject shot					
Division spital or Attendir tours after death.	ertification:	3 Suicide 6 Could not be determined (Specify) Sidewalk	ome, farm, street, factory, office building, etc.	or Town, Sta	reet and Number or Rural Route Number, City ite) Street, Baltimore, MD				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowled one) Physician: To the best of my knowled one)	ige, death occurred at the time, date and place, and/or investigation, in my opinion, death occurre	ind due to the cause d at the time, date ar	(s) and manner as stated. nd place, and due to the cause(s)				
To with To com	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,								
,		Calment	O.C.M.E.		May 29, 2010				
X		30. Name and address of person who completed cause of death (Item Zabiullah Ali, M.D. Assistant Medical Examiner		21201					
S Regis	tate		ure		on HE				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Yea Physician/ Month a^{M} 06:11 Elisabeth Drake June Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Co. Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 **X** F Director Germany 220-56-1036 Usual Residence of Decedent or 28a-f show notified at 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 🗆 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21061 303 Scotts Manor Drive United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married 1 Yes If Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beauty Beautician Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zeiser George Caroline Regner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Robert Drake / Husband Scotts Manor Drive Glen Burnie, MD 21061 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery 06/08/2010 | Crownsville, Maryland Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition more Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for 1 in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death the 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗵 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🗷 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After (Month, Day, Year) 1 🗷 Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) EN. D-40521 DRIVE SWITE 208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 MOSPITAL OCHANEY PLEN BURNIE MD 21061 31. Date filed (Month, Day, Year) State

Registrar

JUN 03 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2perME, G904, 6/9/2010, WS
State of Manyland / Department of Health and Mental Hygiene

			For State of Mar State Registrar	ryiand / Depa <i>Cer</i>	artment of F tificate of L		,	lene leg. No.	10	17000
	Physicia	n/	Decedent's Name (First, Middle, Last)				2. Date of Dea Mont Hay Maren 3		Year	3. Time of Death
	Medic	al	John Thomas Erbe 4a. Facility Name (if not institution, give street and number)		45 C't T	denting (D)				1:00PM
_	Examin	er	12 Hanford Drive		4b. City, Town, or Harmans	ın	4c. County of Death Anne Arundel			
	Funeral Director		219-16-0530 1 ^{™ 2 □ F}	n yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 25	9. Birthp Count Mary	lace (State or Foreign Pland
	and show at	or	Usual Residence of Decedent 10a. State 10b. County 1t	0c. City, Town or Loc	cation				11	0d. Inside City Limits
	Maryla 28a-f otified	Director	MD Anne Arundel	Harmans				1 ☐ Yes 2 ^X No		
	th the 3a or the n	ralD	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Coun	try?
	ems 2	Funeral	12 Hanford Drive 11. Marital Status 12. Was Decedent Ever	er in U.S. 13. V	21077 Vas Decedent of Hi	spanic Origin? (S	pecify Yes or No-	USA 14 Bace	- America	an Indian
036	rs after de ral", or it Examine	Completed by F	1 ☐ Never Married 2 ☐ Married 3 ★ Widowed 4 ☐ Divorced Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give Year or Dates.		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 🛣 No		o Rican, etc.)	Black	k, White, e	
5-0	72 hour	plet	15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occupa	ation luring most of wo	rking	16b. Kind of Bu	siness Ind	lustry
72	vithin 7 iene. rr than the M	Con	Elementary/Seconday (0-12) College (1-4 or 5+)		O NOT use retired) cenant	-		Law Enfo	orcen	nent
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Charles Erbe	<u> </u>		18. Mother's Na Anna Tu	me (First, Middle, Nicker	Aaiden Surname)	1	
lary	should and N is ma aumat		19a. Informant's Name/Relationship (Type, Print)		g Address (Street a					
e,	and 2 Health em 27 ther tr		Mary Owens / Daughter 20a. Method of Discosition	4-46 20b. Place of Dispos	th Stree	t # 212				
E O	Page 1 lent of nt: If it ry or o		1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place	· •	Date 2010	20c. Location -	•	Maryland
Balti	permit. F Departm Importa any inju		21. Signature of Fundral Service License		. Name and Addres	s of Facility	1 Home & Road Oden			
ı			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause of each line.	e death. Do not ente					2111	Approximate
-	nysician/	1	Immediate Cause (Final disease or condition	1203 C. 1	erotic	Hen	+DI	JEAS-	2	Interval Between Onset and Death
-	Medical Examiner		resulting in death) Due to (or as a co	onsequence of):						
		iner	Gogueratiany list conordions, if any, leading to immediate cause. Enter Underlying	onsequence of):					_	
	executed an and rial-transii	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a co	onsequence off:					\rightarrow	
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09/8 8	tificate be ng physici as the bu	Med	IF FEMALE:							
Rox 68	v requires that the death certific, been signed by the attending p. should be detached for use as	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	Fetal death 3	Ectopic pregnance Other (specify)	у	-vid-read	23d. Date Mon		ry Day Year
л О	hat the led by detach	y Ph	Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tok	acco use contrib	oute to the	e cause of death?
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Division of Vital Records,	The law requires that the rate has been signed by the page 2 should be detach	Completed					24a. Was ar autops perforr 1 \(\sum \) Yes	y pr	ere autoprior to coneath?	sy findings available inpletion of cause of
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<u> </u>	Physic this c	욘	THOSPILAL	2 ER/Outpatient	t 3 DOA Othe	4 U Nursing F	lome 5 Reside			
o uo	inding ath. r: After re fune	icate	1 Natural 5 Pending (Month, Day, Ye Accident Investigation		work	Yes 2 No	28d. Describe ho	w injury occurred	J	
JINISI	al or Atte s after de l Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - building, etc. ⟨S	- At home, farm, stree Specify)					or Rural I	Route Number,
	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 of the physician of the funeral director, page 2 of the funeral director.	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam 3 Certifying Nurse Practioner: To the bes	nination and/or investi-	igation, in my opinio	n, death occurred	at the time, date and	d place, and due	to the cau	se(s) and manner stated.
	To th To th		29b. Signature and title of certifier	Deputy	29c. License	number	2	9d. Date signed	(Month, D	ay, Year)
			30. Name and address of person who completed cays of death	h (Item 23a) (Type, Pr		0605	4	6/2	1 -	0
			William P. Jones	mD	69	5 An	revici	9 3	103	35
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's	Signature A.	barre					

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Albina Joan Ewing 6:000 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Baltimore Center 7. Age (In yrs. last birthday, Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 212-18-0488 Months Days 1 □ M 2 🕮 Hours repth. 2 y 1921 MaryTand Director Usual Residence of Decedent 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified Baltimore MD 1X Yes 2 □ No 10e. Street and Number ö 10f. Zip Code 21213 10g. Citizen of What Country? be Funeral 3214 Cliftmont Avenue 23a USA must ral", or items? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Albina Cuiva Iltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes If Yes, Give _{Specify:} white 1 Yes 2 No Specify "natural" 3 ₺ Widowed 4 □ Divorced Year or Dates Ith and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
Baltimore County (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stanley Dapkunas Anna Raila 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Helen Bush-cousin 505 West University Parkway Apt.E12, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State June **3**,2010 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 ordiae L. ME tadd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of) Examiner ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) burial-transit PUL MONARY DISEASE that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical SACRAL DECUBITUS ULCER Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 X No 1 Tes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 📉 No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

Director: After this 27. Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes Accident 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) upleted filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and t D25886

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of d

32. Red

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31. Date filed (Month, Day, Yea

ath (Item 23a) (Type, Print)

TOWSON,

DRIVE

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Physician/ 363 2010 8:05 A M Edith Fosler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2🗓 F Days Hours Min Aug. 21, 1914 Country) 216-09-1236 MI 95 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at within 72 hours after death with the Maryland Director 1 Yes 2X No Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral items 23a 21061 U.S.A. 402 N. Broadview Blvd 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or <u>۾</u> Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည Gustav Schadler Mary Pagel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Lynvue Road Linthicum MD 21090 Mr Robert P. Fosler/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem.Park 2010 Elkridge, Maryland Signature of Funeral Service Licer 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the bunal-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year the 9 Unknown 9 Unknown P.O. | ed by tl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be det Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy perform 25. Was case referred to medical of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 1 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural iniury 5 Pending Division within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year ARIL 04:26 AM /Medical 2010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1 Baltimore | 1/2 | Baltimore | 1/2 | 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | (Month, Day, Year) Good Samaritan Hospital 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 1 □ M 2 🗹 F Yrs. 218-46-2493 Director March 22, 1948 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, It w Modical Examination and other traumatic event, It w Modical Examination and once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore 1 Dayes 2 □ No Maryland NIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 (2.3 9

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Elementary/Secondary (0-12) College (1-4or 5+) 10 Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisy Williams ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Battimore, MD 21239 Ramblewood Mr. Delroy L. Foster 1805 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 \$\mathbb{D}\$ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 □ Other (Specify) King Dane 4, 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CALVIN L. WILLIAMS Funcial Service, Fredhilton Ba Ho; mg 2/229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LIVER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ancreadit Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and Exami Dive to (or as a consequence of): attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a I be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Atter this certificate has been sufuneral director, page 2 should have 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ **N**o 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Man or of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 □Yes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

State Registrar

ZAFI

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAHR

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DHMH 17 Rev 1/2001

KES

5601 Loch Raven Boulevard, Baltimore Maryland 21239

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Joan Frances Fredericks Medical May 28, 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4307 College Ave Ellicott City Howard if Under 1 Year Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Days Hours (Month, Day, Year) 1 M 2 Country) Director 217-38-3839 MD Oct 27, 1940 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location Examiner must be notified at 10d. Inside City Limits Funeral Director 1 Yes 2 No Howard **Ellicott City** 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4307 College Ave 21043 Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Completed by 1 Yes 2 If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → Specify: 3 Widowed 4 Divorced Mit 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harvey M. Quimby Mary Helen Dorffner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lankford Daughter 4307 College Ave Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 Z Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Old Oakland Cemetery Jun 01, 2010 Sykesville, MD 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Pa 1. It is the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause in a ch line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? been signed by the atte should be detached for Day Year 1 Yes 2 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hyperteusian 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only op 29b. Sign 29c. License number ast 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6V 120 North Rolling Record Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

10-04111 Mary Gaston

1- For State

(Disease or injury that initiated events resulting in death) Last

Registrar

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 17205 Certificate of Death Reg. No Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Year 2025 hrs May 29, 2010 4b. City. Town, or Location of Death 4c. County of Death Rosedale **Baltimore County** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Maryland Months Days Hours Min June 9,1928 81 Yrs 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 21234 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes white 1 Yes 2 X No specify f Yes. Give Year Specify. 16b. Kind of Business/Industry

Physician/ Mary Katherine Gaston Medical Examiner 4a. Facility Name (if not institution, give street and number) Franklin Square Hospital 5. Social Security Number 6. Sex Funeral Director 214-26-9214 1 M 2 X F Usual Residence of Decedent 10a State 28a-f show MD Baltimore or items 23a or 28a-f shormust be notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e. Street and Number 9847 Harford Road Funeral 1 Never Married 2 Married 3 X Widowed the Medical Examiner 4 Divorced ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Switchboard Operator 21215-0036 17. Father's Name (First, Middle, Last) marked Ethel Hedrick Be Charles F. Ward 19a. Informant's Name/Relationship (Type, Print) item 27 is r Q W Rodney Gaston-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. portant: **Physician** /Meldical a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of). Examiner cause: Enter Underlying Cause

St.Joseph Hospital 18.Mother's Name (First, Middle, Maiden Surname)

> Approximate Interval Between Onset and

Death

Year

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 746 Monarchos Drive, Havre de Grace, Maryland 21078 20c. Location - City or Town, State Date

X Burial 2 Cremation 3 Removal from State Parkwood 4 Donation 5 Other Specify:	od Cemetery	June 5,2010	Parkville,Mar	ryland
1. Signature of Funeral Service Licensee and ME Fulfor	22. Name and Address of Facilit Exans Funeral Char 8800 Harford Road	rel and Cremet Parville, Mary	ion Services Land 21234	
3a. Part I. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as o	ardiac or respiratory arre	est, shock, or heart	Approxim

Due to (or as a consequence of):

UNPENDED **AMENDED** IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery

23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown diabetes mellitus

24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes

Completed 25. Was case referred to medical 26.Place of Death (Check only one) Be Other4 Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 Yes ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No Pending Accident

2 _ Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ORIGINAL

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 31, 2010

address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) egistrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006

Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed

Physician/Medical attending physician or use as the burial

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the

page 2 should be

director

the

Medical

certificate has been

After this

death.

within 24 hours after death To the Funeral Director:

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Josephine Catherine Geppi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Manor Care Ruxton Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Months Days Hours Min. 90 Director 212-28-2034 April 1920 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Involved Evan, and it use to notify and **Funeral Director** 1 ☐ Yes 2 No Marvland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 Charles Street 21204 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Completed by Specify: Specify 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Restaurant n/a Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F ည Vincent James Barranco Josephine Amato 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Charles V. Geppi/son 842 Gaming Square, Hampstead, MD 21074 permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation St Joseph Cemetery 6/3/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland sign 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that cay led the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ANo Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide ò within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

N. Charles Street, Towson, MD 21204

of death (Ite 3a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28Day 201YO MaryAnn E. Gould M智學 1:53a_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Middle River Baltimore Vailthorn Road 2229 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 288-20-9408 8. Date of Birth **Funeral** Country) Ohio Months Hours Min (Month, Day, Year Feb. 25, 84 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Middle River MD Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 2229 Vailthorn Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 → Widowed 4 □ Divorced White Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CertifiedNursingAssistant Family Services permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other I any injury or other traumatic event, the <u>2yrs</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leo Delanty Mary McGinty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Gould /daughter 2229 Vailthorn Road Baltimore MD 21220 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus 6/2/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave. Balto. MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the dwth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lige. Connelly Funeral Home of Essex 21221 Interval Between Onset and Death Immediate Cause (Final CMCC Physician/ was disease or condition Medical resulting in death) Due to (or as a consequence of) manth Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed and -tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ethyraidism Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 No 1 Tyes Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔏 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 10068057 ompleted cause of death (Item 23a) (Type, Print) 30. Name and addless of person who Baltmare MD 71220 atheir 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 7/2009

		1 - For State Registrar		-		icate of L	ealth and M Death		Reg. No.		1/208
Physic		Decedent's Name (First, Middle,		nder	,			Month 05	Day 31	2010	3. Time of Death 2:48 P M
/Med Exam		4a. Facility Name (If not institution,	give street and number)		4b	. City, Town, or	Location of Death	- 05		ty of Death	2.401
Exam		St Elizabeth	Nursing a	nd Reha	ab :	Baltim	ore				
Funera Directo		219 16 6649	5. Sex 7. Ag 12⊠ M 2□ F	ge (In yrs. last bin 86		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 04 30	1924	Coun	lace (State or Foreign try) yland
land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location	on				10	0d. Inside City Limits
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r 289	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	What Coun	itry?
23a o		209 Chelsea	Rd				21122		U.	S.A.	
S LIE	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	13. Was	Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americ ack, White,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z1 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event. If a Modical Examinal must be inclifted at ODGs.	Ď	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 □ Yes 2 K If Yes, Give Year or Dates:	No		Yes 2⊠ No			Spec	ifv	hite
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the street	ပိ	17. Father's Name (First, Middle, La	ast)		Jongs	STIOL CITE	18. Mother's Name	(First, Middle,		_	
Is marked or raumatic eve	To Be	Charles	A. Grund	der			Kathe	rine	Schne	eider	
umat	-	19a. Informant's Name/Relationshi	o (Type, Print)	19b	. Mailing A	ddress (Street	and Number or Rura	al Route Numbe	r, City or Tow	n, State, Zip	Code)
er tra		Margaret Nicke	el-Webb/ r	niece	821	Cedar	Branch	Dr G	len Bu	rnie	MD 2106
f item		20a. Method of Disposition 1 Burial 2 □ Cremation 3	I □Removal from State	20b. Place of cemeter	f Disposition ry, cremato	on (Name of ory or other place		Date	20c. Location	- City or To	wn, State
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page 2	dmo	1170						autor perfo	rmed?	death?	psy findings available mpletion of cause of
rector, pag	a	25. Was case referred to medical					26. Place of Deat	l ∏ Yes		1 🗆 Yes	2 L No
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completely filled in by the fune	ž	29b. Signature and title of certifier				29c. Licens		1	29d. Date sig		
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ichael Edward (7. State of Maryland / Department of Picture of		ygiche Reg	ZUII	1 . 1209	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death	
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Funeral Director		0.12 56 2605	Months Days Hours Min	_	For	eign Long Beach, Country) California	
Director	-	213-56-3685 1XM 2F 60 Yrs. Usual Residence of Decedent		TEICH T	3, 1550	" Callionna	
any	-	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
<u> </u>	٦	Maryland Prince George's Greenbelt				1 X Yes 2 No	
Maryla 28a-f	Director	10e. Street and Number	Of. Zip Code	100	. Citizen of What Co USA	ountry?	
WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once		22 Ridge Road	20770	nosify You or No		erican Indian, Black,	
ith wit tems 2	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, s	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.		
ter des		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	s 2X No specify:		Specify: W	hite	
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Completed	12		e (First, Middle, Ma			
15-0	BeC	17. Father's Name (First, Middle, Last) Joseph F. Galvin		h Virgin			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examines.	P P	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	dress (Street and Number or				
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Baltimore, M pernit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traum		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition crematory or other leads to the lead of Disposition crematory or other leads to the lead	place)	Date	·		
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Baltimore, permit. Pages I at Department of Hee Important: If ite		21. Signature of Turistal delivree Electrises	e and Address of Facility h's Funeral Ho	mo DA I	379 Balt:	imore Avenue	
	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n	mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval	
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760, icate be e physicial the buria	Physician/Med	IF FEMALE: AMENDED 23a, 27, per ME g904 23c. If yes, outcome of pregnancy	0/10/10 11		23d. Date of deliv	•	
687 ertifica ding p	ian/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal of the past 12 months?		nancy	Month	Day Year	
Sox 687 death certific e attending for use as the	/sic	4 Pregnant at time of death 5 Other 1 Yes 2 No 9 Unknown 9 Unknown	(Specify)		1		
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F Vit Physic r this	70	1 V Yes 2 No Inpatient 2 ER/Outpatient 3	BOA 1 4 11dis	<u> </u>	Residence 6 🗸 O	ther. Scene	
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Ivision or Attent after death Director:	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, f	factory, office building, etc.			Rural Route Number, City	
Under the state of							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit	al C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	d at the time, date and place, ar	nd due to the cause	e(s) and manner as	stated.	
Co the vithin Co the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		at the time, date a	29d. Date signed		
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		May 31, 2010	, 23,, 30,	
ot		Mayere merrill	3.0		, - 1, 1		
and		Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Pen	nn Street, Baltimore, MD	21201			
Y V	tate	Loo Paristado Signatura					
Regis							

DHMH 17 Rev 1/2001 OCME 2006

Registrar

10-04153	
Paul Grey	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ıl Grey		1- For State	yland / Departn <i>Certifi</i> d	nent of H cate of D		Mental Hy		201 eg. No.	0 7210			
Physici dical Exami		Registrar 1. Decedent's Name (First, Middle,Last)	Paul Gray				2. Date of Dea Month May 31, 2	ith Day Year	3. Time of Death 1117 hrs			
		4a. Facility Name (if not institution, give street and 2425 Mt. Hebron Drive	number)		City, Town, or L Illicott City	ocation of Death		4c. County of I Howard	Death			
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last bi		Months Days	If Under 24Hrs Hours Min.	7		9. Birthplace (State or foreign MD			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Usual Residence of Decedent 10a. State MD 10b. County Howard	tate 10b. County 10c. City, Town or Location						10d. Inside City Limits 1 Yes 2 No			
		10e. Street and Number 2425 Mt. Hebron DR. 10f. Zip Code 21042						10g. Citizen of What Country? U.S.A.				
	by Funeral				specify Cuban, I	anic Origin? (Sp Mexican, Puerto specify:	14. Race - American Indian, Black, White, etc. Specify: Specify:					
	Completed t	15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) Colleg	of working life. I Carp	on (Give kind of v DO NOT use retirenter	red)	16b. Kind of Business/Industry Home Building						
	Be Co							irst, Middle, Maiden Surname) Thelma Friedman				
	7	19a Informant's Name/Relationship (Type, Print) Bonnie Grauer Daughter 20a. Method of Disposition		26 Hight		ockeysville			. ,			
		1 Burial 2 Cremation 3 Remove 4 Donation 5 Other Specify:	of from State Crema	atory or other plantic Cren	natory, LLC	Jun	04, 2010		n Burnie, MD			
	1	21. Signature of Fun-ral Service Licensee 23a, Part I, Enter the disease, or complications the	LUOIZGB		3871 Old C		ke Ellicott (City, MD 21043	Approximate Interval			
Physician /M i al Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Intraoral	Gunshot Wound						Between Onset and Death			
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	siciar	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):										
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Vital ysician: his certif director,	å	25. Was case referred to medical examiner?	Inpatient 2 ER/0	Outpatient 3		of Death (Check of ther Nursin		Residence 6	Other: Scene			
After funera	ition: To	1 Natural 5 Pending FOW	ate of Injury 28b. onth, Day, Year) FO	o. Time of Injury DUND: 07 hrs		at Work?		how injury occurred				
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Accident Investigation 1 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Runder 1 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Runder 1 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Runder 1 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Runder 1 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Runder 1 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Runder 1 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Runder 1 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Runder 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Runder 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Runder 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc										
	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	Σ	29b. Signature and title of certifier When Branch		29c. License O.C.M	(Month, Day, Year)							
121		O. Name/and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
St Regist	ate trar	31. Date filed (Month, Day, Year) 2010 32.	Registrar's Signature	Spark	W							

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Hospital or Attending Physician: 24 hours after death.

Registrar DHMH 17 Rev 1/2001

31. Date filed (Month

29a. Certifier 1

Signature and title of certific

Victor Weedn MD JD

Medical

State

DCME 2006

and manner stated.

Assistant Medical Examiner

32 Registrar's Signatur

Breun

30. Name and address of person who completed cause of death (Item 23a)

OCME

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 23; 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MA Pay Physician/ Adele Victory Heckler 29. 4:16PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Funeral 1 □ M 2 🗓 F Davs Hours Min. (Month, Day, July 23 Country)
Maryland Director 1942 214-40-6866 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and the models. 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Balto. Kingsville Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21087 USA 12214 Kingswood Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Executive Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret DiViola Nicholas Massoni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12214 Kingswood Lane Kingsville, Md. 21087 Shawne O'Connor DTR. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 0aklawn 6-3-2010 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd, Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SESPIS disease or condition # Medical resulting in death) Due to (or as a consequence of): Examiner PANCREATIC CANCER Sequentially list conditions, Examine Due to lor as a consequence of : If any leading to immediate cause. Enter Underlying physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events HEPATIC ABSCESS Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🗓 No for Year Month Day Pregnant at time of death page 2 should be detached q Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PLEURAL EFFUSION certificate has autopsy performe 2 **X** No 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death

1 Natural
2 Accident Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending s after death. 1 Yes 2 No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State, 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the back of examination and/or investigation, is my opinion, death assumed to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse/Practioner/ To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of co 29c. License number 29d Date signed (Month, Day, Year) D46356

DHMH 17 Rev 7/2009

State Registrar 7601 OSLER DRIVE TOWSON,

MARY

AND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

TABASSI

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:30 A . M Edna Ruth Hahn 1m Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arundel Anne Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Sep 18, Hours Onio 1 □ M 2**XX** T922 87 Director 282-18-3465 Usual Residence of Decedent rral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 1 Yes XXNo MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21114 1405 Nassau Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XX No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 🏋 No Specify. White 3 XWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Library +6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Antall Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405 Nassau Drive Crofton, MD 21114 Mr. Robert Hahn / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial **XXX**Cremation 3 ☐ Removal from State 3 2010 June Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Singleton Funeral and Cremation . Signaturi uneral ervic Glen Burnie, MD 21061 Services, PA 1 2nd Ave SW Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition VAVMON Medical resulting in death) Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami burial-transit and Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) 9 Unknown detached 9 Unknow cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မြ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 \square Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Txcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie mo 20 V dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

State Registrar 31. Date iled (Month, Day, Year)

10-04056 Sandra Harkleroad

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.												
Physician/		1. Decedent's Name (First, Middle, Last) 2. Date of Death								.,		3. Time of Death		
Medical Exami		Saundra Lee Harkleroad							Month May 27, 2	fonth Day Year ay 27, 2010			1744 hrs	
		4a. Facility Name (if not institution				4b. City, To	wn, or Lo	cation of		, , , ,		County of	Death	
		Harbor Hospital				Baltimo	ore							
Eumaral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast hirthday)	If Under	1 Year	If Under	24Hrs	8 Date of B	irth/MM/D	DAYYYY	9. Birth	place (State or
Funeral Director						Months		Hours	Min		•	1	Foreign	
5		218-90-7448	1 M 2 X F	48	Yrs					March	2,15	102	Cour	ntry)Maryland
		Usual Residence of Decedent										10d. Inside City Limits		
# A	Ì	10a, State 10b, County		roe. City,	Town or Locat	on							- 1	
and show	ъ	PA York Delta									1 Yes 2 X No			
ɗaryland 28a-f show any 1.at.once.	ect	10e. Street and Number					10f. Zip Code				10g. Citize	en of Wha	at Count	ry?
th the Maryland 23a or 28a-f sho notified at once	Director	216 Lakeview		17	314					USA	4			
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ral Examiner must be notified at once	<u>ra</u>	11. Marital Status		cedent Ever in U.		13. Was Decedent of Hispanic Origin? (Specify Yes or No-						4. Race -	- America	an Indian, Black,
eath item	Funeral	1 Never Married 2 X M	arried Armed F	orces?	If Y	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White						White,	etc.	
rer d		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 V No specify: Specify:						Whi	te					
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", cevent, the Medical Examiner.	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done						16b. Kii	16b. Kind of Business/Industry					
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d wit	ĕ	17. Father's Name (First, Middle	, Last)		L		1B	.Mother's	Name (F	irst, Middle,	Maiden S	urname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	Mamian I D										,		
212 lld be Ment mark	To B	Marion J. Do			19b. Mailing	Address				Mary 1		or Town	State	Zip Code)
O 용요하다	-	Dwayne M. Hark		Uuahan									,	,
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Baltimore, MD 21215 permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If item 27 is marked injury or other traumatic event, t		Burial 2 XX Cremation	n 3 Removal fr		crematory or oth								•	
imc Pag ment tant: or ot	1	4 Donation 5 Other S	pecify:	At1	antic (M	lay 3	1,201	G16	en Bu	ırni	e MD
Balt permit. Depart Import injury	- (21. Signature of Funeral Service	tricensee	hard	22. N	ame and A	ddress o	f Facility	Ambı	ose F	unera	al Ho	me	of Lansdown
0 8 9 2 3	M BARE 2719 Hammonds Ferry Road Lansdo									lowne	e MD	21227		
Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the death.	. Do not enter th	ne mode of	dying, su	ich as cai	rdiac or r	espiratory ar	rest, shoc	k, or hear	t	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease		one into	oxicati	on							- 1	Death
Examiner		or condition resulting in death)		consequence o										
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Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be executed ours after death. eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	X UNPENDED	T AMENDED	#1 as no	oted ne	r ME	2904	6/2	3/10	TT			\rightarrow	
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760, ficate be g physic the bun	≥	IF FEMALE: 23b. Was decedent pregnant in t		outcome of pregi	nancy		₂ [Ectopia	prognanc	v		Date of d		y Year
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Box 68's death certiff the attending of for use as	Sic	1 Yes 2 No 9 V Unknown G Unknown												
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e Hoo 24 h e Fur etely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									cause(s)			
Laro	ž	29b. Signature and title of certifier 29c. License number 29d. Date signed								d (Monti	h, Day, Year)			
		2-10-				O.C.M.E.			May 28, 2010					
	ŀ	30. Name and address of persor	who completed caus	se of death (Item	23a)									
		Donna M. Vincenti, M		/ledical Exan		Penn St	reet, E	Baltimo	re, MD	21201				l
0	ate	31. Date filed (Month, Day, Year)		egis ar's Signatu		4								
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL 29 2010 ear **Physician** 9:34 A.M. LULA HOWARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 2/11/12 3 321 Social Security Number **Funeral** Min. 1□ M 2🍎 F Months Days Hours 422-40-4639 77 **Director** ALABAMA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at 1 XYes 2 No Director WASHINGTON DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with UNITED STATES 1002 TAYLOR ST., NE 20017 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: Specify: BLACK 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. ۾ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) PRIVATE PASTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANNIE BELL MOORER ELIHUE MOORER ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MICHEAL MONTGOMERY/SON 1002 TAYLOR ST., NE WASHINGTON, DC 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If iter
any Injury or ott 1 ☐ Burial 2 ☐ Removal from State CHESAPEAKE CREMATORY 5/11/10 BELTSVILLE, MD Donation 5 Other (Specify) 22. Name and Address of Facility f Funeral Service 22. Name and Address of Facility
CAPITOL MORTUARY 1425 MARYLAND AVE., NE WASH., DC 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Week disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a conjequence of Hospital or Attending Physician; The law requires that the death certificate be executed the burial-trai as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 🙀 No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌠 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No 24a. Was an autopsy 1 □Yes No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours at 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30, 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 CARROLL KARIM, KVB, STC340, TAKEMARLES MS 2097 31. Date filed (Month, Day, 32. Registra 's Signature State Registrar 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G904,6/3/2010,WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Рм George Stanley Hart aka George Joseph Hart May 26, 8:35 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Advantist Hospital Takoma Park Montgomery 8. Date of Birt**6-25-1920**9. Birthplace (State or Foreign (Month, Day, Year)
June 29, 1920
Washington, DC 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Davs Min. 1 🛛 M 2 🗆 F Months Hours 578-05-4194 89 Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Prince George's Hyattsville Maryland ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5805 Queens Chapel Road 20782 **IISA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Nidowed 4 Divorced WWII Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hardware Store Account Salesman 12 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be Raymond Hart Annabel Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Robert D. Elam / Nephew 14656 Peddicord Road, Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 6/3/2010 Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1056 KO. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of and I-transit death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last /sician a Physician/Medical phys the t attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No ed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown that the s been signed to should be detr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page certificate 1 Yes 2 No Yes 2 X No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No 1 🗌 Yes ပ 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Deatl 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After X Natural injury 5 \square Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month) Day, Year) 1)60096 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Jacobs, 7600 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) State

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Registrar

Box 68760

P.O.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician/ JUNE 01 2010 11:00 AM HENRY W.HILGEMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD FOREST HILL HEALTH& REHAB CENTER FOREST HILL Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Jan - 8 1 ★ M 2 🗆 I 1924 217-18-2598 86 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗌 Yes 2 🔀 No Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10020 Crane Lane 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc 1 Never Married 2 Married ☐ Yes 2 😿 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 Mo Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Universal Food 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Laura Reed Henry W. Hilgeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crane Lane Baltimore MD Ramona Hall /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1
Burial 2
Cremation 3
Removal from State Department of Important: If any injury or Bayview Crematory 6/5/10 Baltimore MD 4 Donation 5 Other (Specify) permit. . Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Home of Essex Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician kion Medical resulting in death) Due to (or as a consequence of): Examiner 772 Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exam or Attending Physician; The law requires that the death certificate be executed as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the accompleted filled in by the funeral director, page 2 should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 1 Tes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NO မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 🔍 5 Pending M Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year, 3229 JONE 1 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6V DR DAVID DUNN 615 W.MACPHAIL ROAD SUITE 106 BelaIR MD 21014

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>010</u> Month Physician/ 5:05 РΜ Susan Frances Hack May Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's College Park 9300 Cherry Hill Road, Apt #203 8. Date of Birth (Month, Day, Yea April 9, 1 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Days 1 □ M 2 🕱 F 213-98-8037 45 Cheverly, Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No College Park Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 20740 IISA 9300 Cherry Hill Road, Apt #203 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black White etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. I **other than** " Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Assistant Goverment 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ္ James Donald Fink Frances Jean Mayhew of Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Park Hall South, Laurel, MD 20724 George Anthony Hack / Husband other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1. Department of Important; If it any injury or or cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 6/1/2010 Alexandria, Virginia Metropolitan Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, PA ase 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Artery Risease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Orderlying Cause (Disease or iinjury Hypercholesterolemia To the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 🗌 Yes 2 🗆 No Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 X ER/Outpatient 3 IDCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မှ this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 | Medical Expansion: To the Desit of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Expansion: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 | Certifying fluyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title

Registrar

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31. Date filed (Month, Day, Year)
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rson who completed dause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ David, Harrison Day 05 m 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UMMC Ballimore, Ballimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 04 | 0 | | 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F 218-74-1747 |MaryTand 52 Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director Cockeysville MD1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? Gibbons Funeral 2/030 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1₁⁴ or 5+) Computer Tech Installer Computer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirlev Fix S. Frank Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22 Gibbons Blvd. Cockeysville, Maryland 21030 Shirley Harrison / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Hill top Service Corp. 6/2/2010 Towson, Maryland 4 Donation 5 Other (Specify) Signature of Funeral 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Circhosis Physician/ Medical resulting in death) Examiner day Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year certificate has been signed by the irector, page 2 should be detached g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 Natural 2 Accident (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

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32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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Ballimore

29d. Date signed (Month, Day, Year) 31

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Street

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death 6:20 p 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Day May 2010 р Huber <u>Florence</u> Mary Medical 4a. Facility Name (if not institution, give street and number).

Greater Baltimore Medical Center Towson 4c. County of Death Baltimore **Examiner** Towson Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 29 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Hours Director 212-03-9474 Georgia Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 XNo Baltimore Maryland Timonium 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21093 2300 Dulaney Valley Road, M206 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other traumatic event, the Nonce. Retail Sales Store Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Furletti Franzoni Andrew Laura 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print) 12246 Roundwood Road, #405 Timonium, Maryland Jeffrey G. Huber Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6-2-2010 Towson of Funeral Service Licensee 21. Sign 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 1050 York_Road Towson, Maryland an Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as consequence of) Examiner 5 squartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗷 No certificate 1 🗌 Yes **Division of Vital** or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Motogi, D52197 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC 6701 N. CHARLES ST. BALTIMORE, ND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5 07:55 AM **Physician** ANNIE HARBOR 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL BALTIMORE NORTHWEST 12ANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1□M 2XF 87 Yrs. Aug. 14, 1922NorthCarolina 241-18-5379 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show r than "neturel", or items 23a or 28a-f shov the Madical Examiner must be mutified at 1 ☐ Yes 2 No Randallstown Funeral Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21133 8686 Side Saddle Court death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or iten any injury or other treumetic event, the Medical Examines once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Tobacco Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Love Nelson Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type, Print) 8686Side Saddle Court, Randallstown, Maryland Ronald K. Harbor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Greenview Cemetery 6-5-10 Reidsville, N.C. 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. muchau 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal Carcinoma + metaltaens with Privsician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? e Hospital or Attending Pl 24 hours after death. e Funeral Director: After t Certification: 1 Natural
2 Accident 5 Pending investigation 1 TYes 2 □ No 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2010 D65041

10/

Registrar

State

Jacka

32. Registrar's Signature

2600 LIBERTY HTS AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMBACAVANAN BACASURRAMANIAN

31. Date filed (Month, Day, Year)

JUN 03 2010

a Fecility Neme (If not institution, give str Larkin Chase Nur Social Security Number 6. Sex 10 Nur Social Security Number 10 Security Number	Sing Home 7. Age (In yrs. last 101 10c. City, T Stro Was Decedent Ever in U.S. Armed Forces? 1 Yes 20 No H Yes, Give Year or Dates: tion ompleted) College (1-4or 5+)	birthday) If Under 1 Year Months Days fown or Location Dng 10f. Zip Code 71765	spenic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.) Specify: ution uting most of working	Day 20 ath 4c. County of Prince Birth Day, Year) 3 , 1908 10g. Citizen of Will U.S.A. No- 14. Race Black Specify: 16b. Kind of Bus	e George's 9. Birthplece (State or Foreign Country) LOUISIANA 10d. Inside City Limits 1 Yes 2 No het Country? - American Indian, t, White, etc. Black siness/Industry
a Fecility Neme (If not institution, give str Larkin Chase Nur Social Security Number 6. Sex 10 Nover Married 10 Never Married 11 Never Married 12 Never Married 13 Decedent's Education (Specify only highest grade of the company (Specify only highest grade of t	Was Decedent Ever in U.S. Armed Forces? 1 1 Yes Year or Dates: tion ompleted) C Sing Home 7. Age (In yrs. last 1 0 1 10c. City, T Stro	birthday) Yrs. If Under 1 Year Months Days Fown or Location Dng 10f. Zip Code 71765 13. Was Decedent of Hill If Yes, specify Cubar 1 Yes 2 No 6e. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired,	If Under 24 Hrs. B. Date of (Month, July 8) Spenic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.) Specify: Ittion Uniting most of working	Prince Birth Day, Year) 3, 1908 10g. Citizen of WI U.S.A. No- 14. Race Black Specify: 16b. Kind of Bus	of Death e George's 9. Birthplece (State or Foreign Country) LOUISIANA 10d. Inside City Limits 1 □ Yes 2X No het Country? - American Indian, t, White, etc. Black siness/Industry
Larkin Chase Nur Social Security Number 431-72-0580 Suel Residence of Decedent Oa. State 10b. County Arkansas Union Oe. Street end Number 733 Bird 1. Marital Status 1. Never Married 2 Married Widowed 4 Divorced (Specify only highest grade of Elementary/Secondary (0-12) 5 7. Father's Neme (First, Middle, Last) George West 19a. Informant's Name/Relationship (Type)	Sing Home 7. Age (In yrs. last 101 10c. City, T Stro Was Decedent Ever in U.S. Armed Forces? 1 Yes 20 No H Yes, Give Year or Dates: tion ompleted) College (1-4or 5+)	birthday) Yrs. If Under 1 Year Months Days fown or Location Dng 10f. Zip Code 71765 13. Was Decedent of Hill If Yes, specify Cubai 1 Yes 2 No 6e. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired,	If Under 24 Hrs. B. Date of (Month, July 8) Spenic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.) Specify: Ittion Uniting most of working	Prince Birth Day, Year) 3, 1908 10g. Citizen of WI U.S.A. No- 14. Race Black Specify: 16b. Kind of Bus	9. Birthplece (Slate or Foreign Country) LOUISIANA 10d. Inside City Limits 1 Yes 2X No het Country? - American Indian, t, White, etc. Black siness/Industry
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Charles Wilson	, Print)	19b. Mailing Address (Street a	and Number or Rurel Route Nur	nber, City or Town, S	State, Zip Code)
			enue,Lanham,		
	noval from State	etery, cremetory or other place	9)		
4 ☐ Donation 5 ☐ Other (Specify)	Fore			OHomer, I	Louisiana
1). Signature of Funeral Service Licensee	a. M.	22. Name and Addres	Marzull	o Funera	al Chapel, P.A
mmediate Cause (Final disease or condition esulting in death) a	DE	MENTIA			Onset and Death
b bequentially list conditions, any, leading to immediate	Due to (or as	a cuitsequence off.			
Cause (Disease or injury nat initiated events esulting in death) Last	Due to (or as	a consequence of):			
d					
art II. Other eignificant conditions contril	outing to death but not resultin	g in the underlying cause give	en in Part I. 23b. D	id tobacco use conf	tribute to the cause of death?
HYPERTEN	4012		1	□ Yes 2NNo	3 Probably 4 Unknown
A			24a. W	as an autopsy	24b. Were eutopsy findings available prior to
MINEAMIA			pe	enormed?	completion of cause of death?
			11	□Yes 2NNo	1□Yes 2X No
5. Wes case referred to medical examiner?		112		ly one)	
TES ZUNO	1 Inpatient 2 ER	Outpetient 3 DOA	4 Nursing Home 5 H		
T G T G T G T G T G T G T G T G T G T G	(Month, Day Year)	Injury Work	(?	se now injury occurre	Su .
3 Suicide 6 Could not be		, farm, street, factory, office	28f. Location	n (Street and Number	er or Rurel Route Number,
4 Li Homicide	building, etc. (Specify)		City of	TOWIT, State)	
9a. Certifier (Check only one) (Check only one)	an: To the best of my knowle : On the basis of examination end manner stated.	dge, death occurred at the tim end/or investigation, in my op	e, date and place, and due to to pinion, death occurred at the time	he cause(s) and mar ne, date and place, a	nner as stated. Ind due to the cause(s)
9b. Signature and title of certifier	ne i			29d. Date signed	(Month, Day, Yeer)
· ya	July 12		-3217	5/26	(10
	Noted cause of death (Item 23	a) (Type, Print) EFBELT RD	COLLEGE PR	(Mg 2	v740
	Da. Method of Disposition 1	20b. Placement of Disposition 1	20. Method of Disposition 1 Signature of Commendation 3 Signature of Signature of Commendation 5 Other (Specify) 1. Signature of Funeral Service Licensee 2. Name and Address of person who completed cause of Disposition (Name of commendation of Commendation (Name of commendation of Commendation (Name of Commendation of Commendation of Commendation (Name of Commendation of Commenda	Date of Disposition (Name of Completed Cause of Feditive Completed Cause of Feditive	20. Place of Disposition (Name of purposition (Name of purposition) (Name of purposition

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J_{une}^{Month} 3, 20^{3} 10 **Physician** 1:30A M MILDRED HENSCHEN JOHNSON /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Edenwald Towson Baltimore If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth Month Day, year) 12/02/1906 Birthplace (State or Foreign
Country) 6 Sev 7. Age (In vrs. last birthday) Funeral 1 ☐ M 2 🙀 F 212-74-2954 103 Yrs. Maryland Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural", or Items 23a or 28a-fehow 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □ Yes 2 XX Directo Maryland Baltimore Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 800 Southerly Road 21286 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (T)No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 X Vidowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Henschen Agnes Zimmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 Is n any injury or other traun once. Susan Johnson Bennett DTR | 1221 Old Pylesville Road Whiteford, Maryland 21160 20a. Method of Disposition
1,□ Burial 2. Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State GreenMount Crematory \ 06/04/2010 | Baltimore, Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Family tchell-Wiedefeld Funeral Home Inc ignature of Funeral Feryice Lig 6500 York Road Baltimore, Maryland 21212 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the dise ve, or complic shock, or heart failur. List only on Immediate Cause (Final dementia Physician stage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 1 ☐ Yes 2 No ursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) R154032 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towsal, MD 21286 Scher CRNP 800 Southerly Rd. 32. Registrar's Signature

DHMH 17 Rev 1/200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ 9:00 Mary Ellen Justice 29 May Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner 6102 Breezewood Court, Apt. #203 Greenbelt Prince George's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number Funeral 6. Sex Days (Month, Day, Y 1 □ M 2 🖾 F 256-84-1611 63 Devereux Director Georgia Usual Residence of Decedent r 28a-f show 10b. County 10c. City, Town or Location 10d, Inside City Limits Director notified 1 X Yes 2 No Maryland Prince George's Greenbelt 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò Examiner must be Funeral 23a USA 20770 6102 Breezewood Court, Apt. #203 items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates **Black** Specify: "natural", 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 12 should be filed within 72 alth and Mental Hygiene.
27 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Willie Mae Watkins Jimmy Lewis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6102 Breezewood Court. Apt. #203, Greenbelt, MD 20770 f Health Tammy Y. Justice / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Heritage Memorial Cem. Waldorf, Maryland 6/3/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Esophageal Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed ending physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 g Unknown Yes 2 X No 4 ☐ Pregnant 9 ☐ Unknown signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 X Yes 2 No 3 Probably 4 Unknown Records, cate has been signated to page 2 should to Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 this certificate of Vital or Attending Physician: after death.

Director: After this certifications 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide To the Hospital within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) 29b. Signature an 6/1/2010 D08754 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bensigner, 7525 Greenway Center Drive, #205, Greenbelt, MD 20770 Thomas A. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20:25 M 2010 10 MAY 8 . /Medical 4a. Facility Name (If not institution, give keet and number) City. Town, or Location of Death 4c. County of Death Examiner 40 waro 8. Date of Birth Min. (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 💢 F Months Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Hnnx 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced lark Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 4 □ Donation 5 □ Other (Specify) 21. Signarure of Fune at Terva Liouns 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician REMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner GROWTH RESTRICTION INTRAU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) requires that the death certificate be executed UFRE the burial-tran resulting in death) Last Due to (or as a consequence of) attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Yea Day 5 ☐ Other (specify) P.O. 9 Unknown signed by I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? or Attending Physician: The law 24a. Was an certificate has autopsy page perform 1 □Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 1 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident MIA NIA 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064450 MD 6350 STEVENS FOREST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCISCO MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

		-	For State	State of	of Maryland		artment d tificate d				00	1.0	117000
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	uncate c	n Dean	1	2. Date of Deat	leg. No. /		3. Time of Death
	Physicia		Susanna		Jackso	n				Month	Day	Year	11:15 AM
)	Medic Examin		4a. Facility Name (if not institution, Union Memori	give street and nur al Hosp	nber) ital		4b. City, Tov Ba	n, or Location	on of Death		4c. County	of Death a	
Ī	Funeral Director		5. Social Security Number 246-52-0718	6. Sex 1 ☐ M 2 🙀 F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 \ Months D	ear If Und ays Hours	der 24 Hrs. s Min.	8. Date of Birth November 129	Yeal 929	g. Birthp Coun N . C	
7	ow t		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Loc	cation						10d. Inside City Limits
dollar	a-f sh fied a	ecto	MD n/	a			imore						¥☐ Yes 2 ☐ No
M ode dei	23a or 28 st be not	Funeral Director	10e. Street and Number 102 W. 27th	St.			10f. Zip Co				10g. Citizen of US		ntry?
Z1Z13-0030	permit, Fage 1 and 2 should be filled within 72 hours siner death with the way yand Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Fo	ye No	l I	Was Decedent f Yes, specify	Cuban, Mexi	can, Puerto	ecify Yes or No- Rican, etc.)	Blac	ce - Americ ck, White,	etc.
Z 13-0030	in / ∠ nours e. kan "natura Medical E	Completed		t's Education st grade completed	1	(Give I	dent's Usual 0 kind of work d O NOT use rei	one during m	nost of work	ing	16b. Kind of B	usiness In	dustry
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yland	nd be med Mental H arked ot atic ever	To B		Harris	on			L	izzie	e (First, Middle, Me Faisc	n		
, mar	o z snou salth and n 27 is m er traum		19a. Informant's Name/Relationsh Brenda Carte		hter)	19b. Mailir 171	ng Address (Si	reet and Nur Lanva	nber or Run	al Route Number, Balt	City or Town, S	212	Code) 13
Baltimore,	rage 1 ar nent of He int: If iter iny or oth		20a. Method of Disposition ★□ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		ce ce	metery cren	sition (Name on matory or othe moria	r place)	i	Date 5,20	20c. Location Dal	•	
Balti	permit, Departn Importa any inju		21 Sonature of Funeral Service L	icensee	INVE	22 C.	Name and A alvin 412 E	ddress of Fa	cruge	js Fun∈ St. Ba	eral H	ome d. 2	1213
р	nysician/	2 8	23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on e	ach line.	Do not ente	er the mode o						Approximate Interval Between Onset and Death
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	ate be executed oblysician and the burial-transit	edical Ex	that initiated events resulting in death) Last	Due to	(or as a conseque	ence of):			·				
09/89		Med	IF FEMALE:										
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J.	ine law requires that the ate has been signed by t page 2 should be detach	d by Ph	Part II. Other significant condition	ons contributing to	death but not resu	ilting in the u	underlying cau	se given in F	Part I.	23e. Did to			the cause of death?
ecord	nysician: The law requinis certificate has beer if director, page 2 shou	Completed by								24a. Was a autop perfo		prior to co death?	opsy findings available ompletion of cause of
<u> </u>	an: Ir tifficat tor, pa	Be C	25. Was case referred to medical					26. Place of	Death (Chec		2 100	1 165	2 110
X	nysici nis cel I direc	10 8	examiner? 1 Yes 2 No		Inpatient 2 □			Other: 4	Nursing H	ome 5 Resid			fy)
ַ סָר	iing P .r After ti funera	ate:	27. Manner of Death 1 ★ Natural 5 ☐ Pendir 2 ☐ Accident ☐ Investi	ig (Mo	e of injury onth, Day, Year)	28b. Time o injury	f 28c	Injury at work?	2 \square No	28d. Describe h	ow injury occur	red	
Division of Vital Records,	or Attency after death Director:	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	te of Injury - At holding, etc. (Specify)	me, farm, sti			2 110	28f. Location (S City or Tow		ber or Rura	al Route Number,
	To the Hospital or Attending Physician: with 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director,	Medical	(Check 2 Medical I	Physician: To the examiner: On the b Nurse Practione	asis of examination	and/or inves	stigation, in my	opinion, deat	th occurred	at the time, date a	ind place, and d	lue to the c	ause(s) and manner stated
	To the virthing to the composite of the	2	29b. Signature and title of certifie					icense numb	er		29d. Date sign. 5 30	ed (Month,	
			30. Name and address of person	who completed ca	use of death (Item	23a) (Type,	Print)	- 11	10.0-1-	D	0 11 -	// (0	MIN 01710
	Sta	ate.	Amy Abdallah, 31. Date filed (Month, Dal, Year)		Registrar's Signat		back		versity	1 icwy	Dainm	ure, I	1110 21218
	Sta	H.	11181		MILLER	. A.	Mark						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d perPHYS. G904.6/3/2010 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 31 Physician/ EILEEN MARY NOCTOR KAVANAGH May 10:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER Bel Air Harford County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign Funeral Apr 26, 1914 1 □ M 2 🔽 F Days Hours 218-12-4970 96 Mary land **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland | Harford County Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1301 Sheridan Place, Apt B 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 9 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. "natural", Specify. 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ be Matthew Noctor Bridget Curran Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Eileen K. Doolittle (Daughter) 1301 Sheridan Place, Apt B, Bel Air, MD 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New Cathedral Cemetery 6/4/2010 Baltimore, Maryland 21. Signal of Fun al S mice deens, CHELL WIEDEFELD FUNERAL HOME 00 York Road, Baltimore, MD 2 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rascular Physician/ disease or condition resulting in death) Medical **Examiner** 1000 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cons // nce of): that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day Year 1 ☐ Yes 2 ₺ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 🗆 Yes 2 🗀 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Date filed (Month, Day, Year) 32. Registrar's Signature 03 Registrar

31/2010

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary 30, 2010 Year Violet Marie Lipple 7:55A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Center Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F 182-14-1252 90 Months Days Hours Min. Aug. 26, Pennsylvania Director 1919 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location Director MD Parkville 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3206 Glendale Avenue 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3[™] Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) At Home Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker should be filed with and Mental Hygien is marked other th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Augusta Chirdon Emmet Holmberg permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1211 Teaford Road-Forest Hill, Maryland 21050 Louise Blackburn-daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Hotel of Disposition (Name of Commercial Com June 3,2010 Baltomore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Fivers Fineral Chartel And Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ea Immediate Cause (Final Physician/ disease or condition resulting in death) , Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by Ischence 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 performed' 1 🗆 Yes 2 🗆 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 NO 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifier 5601 Loch Raven Blue address of person who completed cause of death (Item 23a) (Type, Print) Baken MI

State Registrar 31. Date filed (Morîth, Day, Year)

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\texttt{May}^{\texttt{Month}}$ Physician/ Day 2010 ear 31 5:18а м Irene S. Lucas Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 □ M 2 🔀 F Jan 24 , 1918 213-26-9652 Yrs. Director 92 Usual Residence of Decedent permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturn" any injury or other transments. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 555 West Towsontown Blvd. 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sallie Phoebus Charles V. Tankersley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joggins Court Baltimore MD 21220 Donovan Kropkowski 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 6/4/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fune Pervice Licens 22. Name and Address of Facility 300 MAce Ave. Balto. MD <u>Connelly Funeral Home of Essex</u> 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only one cations that caused to cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate immediate Cause (Final Pnysician/ disease or condition MENTHS Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DEMENTIA Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? ours after death.

eral Director: After this certificate I filled in by the funeral director, pag. 2 No 1 Yes Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ⚠ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрефе Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title a

State Registrar 31. Date filed (Month, Day, Year)

CHARLES ST, SUITE 4105 BALTIMOTE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAN, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear Physician 2025PM ELSA IRENE LUKENICH MAT 2010 7 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES HOSP MAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 05 02 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🛛 F Months Davs Hours 78 219 28 3805 Director Usual Residence of Decedent death with the Maryland 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the fivedical Examination and injury or other traumatic event, the fivedical Director 1 XYes 2□No Baltimore MD 10g, Citizen of What Country? 10e. Street and Number 10f Zip Code 21229 Funeral 10 Rock Glen Rd U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumation. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gabrielle Lukenich Minna Lang ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Allen - niece 312 Old Riverside Rd Baltimore MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 6/2/2010 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility GJ Gonee Funeral Home, 21. Signature of Funeral Service Licenses 169 Riviera Dr Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ISCHEMIA MYOCARDIAL **Physician** DAT /Medical Due to (or as a consequence of): Examiner DAY META BOLIC ACIDOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>Ş</u> ARTERT CORONARY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performe HYPER GPIDENIA 1 ☐ Yes 2 No Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ō 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pi 24 hours after death. Funeral Director: After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ision 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a, Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING D0056948 2010 MAT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATUMONE MO FUITE JAMED TANSINDA 300 ARMORT PLAZE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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			For State Registrar	State of Ma	ryland /		rtment					gien Reg. N	Onin	1723	******
			Decedent's Name (First, Middle, Last)						T	2. Date of De	eath	112 0 1 0	3. Time of Death	1_
	Physicia /Medic		William Ann Lawson	L							Month 5 /	28/3	ay 2010 Year	1754	M
*	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, T	own, or	Location	of Death			c. County of Deat		
4			Laurel Regional Ho				Laure		711				rince Ge		
и	Funeral		5. Social Security Number 6. Se	x 7.Age ☐M2⊠F	(In yrs. last b	oirthday) Yrs.	If Under 1 Months	Days	Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	av, Yea	r) Co	hplace (State or Foreignatry)	-
	Director		432-86-1959 Usual Residence of Decedent		66						1/17/	1944	4 Van	Buren, AR	
	ylanc how		10a. State 10b. County		10c. City, To	wn or Loc	ation							10d. Inside City Limit	s
	a-f s	cto	VA Newport N	lews	Newpor	t Ne	WS							1 N Yes 2 N	0
	or 28	Director	10e. Street and Number				10f. Zip (10g. C	Citizen of What Co		
	s 23a	ra	1356 Roanoke Avenu				2360				'' Y		US.		_
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show officel Examiner mast be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN		13. V	Vas Decede Yes, speci	ent of His ity Cubar	spanic Or n, Mexica	n, Puerto	ecify Yes or No Rican, etc.))~	14. Race - Ame Black, White		
336	Irs aff	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	•	1	□Yes 2	™No	Specify.	•			Specify: B1	Lack	
215-0036	2 hou	Completed	15. Decedent's Edu	ication	16	a. Deced	lent's Usual	Occupa	ation	nt of world		16b.	Kind of Business	Industry	
21	thin 7 ne. nan "r	nple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5-			kind of work OO NOT use	e retired)	uning mos	St OF WORK	ng				
21	filed within Hygiene. other than '			1	L	PN			40.11.0		/Fi	1	rsing		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar transit	Be	17. Father's Name (First, Middle, Last)W. J. Knight					Į.			(First, Middle 1 Simps		en Surname)		
Ž	2 should and Me is mark aumatic	은	19a. Informant's Name/Relationship (7	vne Print)	19	9h Mailin	n Address						or Town, State, 2	Zin Code)	
≥	and 2 s ealth ar n 27 is her trau		Shawna K. Lawson				Foe C:					197			
ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Place ceme						ate		Location - City or	Town, State	
Ë	Page nnt: If Iry or		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Metrop				- ;	6/2/	2010	Ale	xandria,	Virginia	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licens	see	1		. Name and							more Avenu	e
<u>m</u>	89 = 88		K. Sayle 1	As Payers		G	asch'	s Fu	nera	1 Hor	ne, PA	Ну	attsvill	e, MD 2078	1
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lin	the death. D e.	o not ent	er the mode	of dying	g, such as	s cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death	
	Physician	10	Immediate Cause (Final disease or condition	a. Myocard	ial In	farc	tion							Orișet and Death	
7	/Medical Examiner		resulting in death)	Due to (or as a	consequenc	e of):									
		ī.	Sequentially list conditions,	b Due to (or as a	consequenc	e of):									
-	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,	,									
oʻ	an an		resulting in death) Last	Due to (or as a	consequenc	e of):									_
8760,	sate be executed ohysician and the burial-transit	ical		d											
89	leath certifica attending ph I for use as th	Med	IF FEMALE:												
Box 68	ath ce ittend or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 🗆 Fetal dea	ath 3 🗆	Ectopic pr		/				23d. Date of de Month	livery Day Year	
Ö	he de the a	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at g ☐ Unknown	time of death	n 5L	Other (spe	ecify)							
σ.	uires that the de signed by the a d be detached f		Part II. Other significant conditions of	ntributing to death bu	it not resulting	g in the ui	nderlying ca	use give	en in Part	I.	23e. Did	tobacc	o use contribute t	o the cause of death?	
Records,	uires n sign ld be	d by									1 🗆	Yes	2 □ No 3 □ P	robably 4 🖾 Unknow	٧n
000	w requir s been s should	Completed									24a. Was			utopsy findings availat	
Be	The law te has age 2 s	ᄩ	•								auto perf 1 □ Yes	ormed?	death?	completion of cause o s 2⊠No	if
ita	iclan: The certificate ector, pag	Be C	25. Was case referred to medical examiner?						26. Plac	e of Deat	Check only		10 10	2 22110	
>	Physic this ce al dired		1 ☐ Yes 2 ⊠ No		nt 2□ER/	Outpatier			4 U N	lursing Ho	me 5□Res	sidence	6 ☐ Other (Spe	ecify)	
Division of Vital	ding Physician: The n. After this certificate h funeral director, page	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry (, Year) 28t	o. Time of Injury		8c. Injury W <u>or</u> k			28d. Describe	how in	jury occurred		
Sio	ttend death tor: /	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Diese of Inju	- At hame	form at	M		Yes 2		OPt Leasting	104		lumi Danta Alumbar	
Ξ	or A after Direc	ertif	4 ☐ Homicide determined	28e. Place of Inju building, etc	:. (Specify)	, idilli, Sil	eei, iaciory,	, onice			City or To			lural Route Number,	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C		ysician: To the best iner: On the basis of and manner sta	examination										
	To the within Го the	Me	29b. Signature and title of certifier				29c	. License	e number			29d. l	Date signed (Mon	th, Day, Year)	
	. >-0) (/				34	378	3			5/28/10	2	
	1.1	1 1	30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type,	Print)	=	(1	07110700 650	
	l V	1	Scott A. Carter,				Laur	e1,	MD	2070	7			<u></u>	
	Sta		31. Date filed (Month, Day, Year)		ar's Signature										
DI	Registi		JUN 0 3 2010	Denne	B. A	Back									_

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Mark Joseph Liupaeter

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	State of Maryland / Department of He	ealth and Mental Hygiene

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	R	For State				Certif	icate of	Death			Reg	. No.	1 0	1 /	404
Physician/ Medical Examine	1	. Decedent's Name (First			Joseph	Liupa	aeter			1	. Date of Death	Day Yea	ır	3. Time of 1151	_
7	<u>. </u>	a. Facility Name (if not in	stitution, g					b. City, Town, c			Way 01, 20	4c. County of	of Death		
Funeral	5	Carroll Hospital C . Social Security Number		Sex	7. Age ((In yrs. last	birthday)	If Under 1 Ye	ar If Unde		8. Date of Birth			hplace (Sta	te or
Director	L	217-29-8416	1)	Д м 2	F	19	Yrs.	Months Da	ys Hours	Min.	Jul 30), 1990	Foreigr Cou	n intry)	MD
any	-	Isual Residence of Dece 0a. State 10b. C	ounty		10	0c. City, To	wn or Location	on							e City Limits
		MD		Carroll					Elders	spurg					2 No
D tiffe of D		0e. Street and Number 1344 Jay Rd.						10f. Zip Code	217	84	100	g. Citizen of Wh	u.S		
or death with or items 23 runust be no		Marital Status Never Married 2	Marri		/as Decedent E	_	13. Was	Decedent of Hes, specify Cuba	lispanic Orig an, Mexican,	in? (Spe Puerto R	cify Yes or No- ican, etc.)	14. Race White		can Indian,	Black,
s after de ural", or niner m		3 Widowed 4		ed If Yes, of	Give Year	No No		Yes 2 N				Specify:	Wh	uto	
2 hours "natur [Exam	<u>;</u> -	15. Decedent's Education Elementary/Secondary			est grade comp		during mo	s Usual Occup	e. DO NOT	use retire	d)	16b. Kind of Bu		•	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed		,	` ,		1			Ceramic T						rovem	ent
215-(215-(be filed and Hygin riked oth ent, the ent, the Be Co		7. Father's Name (First,	Middle, La	valter (George Li	upaeter			18.Mother	's Name (I	First, Middle, Ma Cynthi a	a Marie O'	Donn	ell	
MD 21215-0036 ad 2 should be filed within 7 th and Mental Hygiene. m 27 is marked other than aumatic event, the Medica To Be Comple	2 7	9a. Informant's Name/Re Cynthia Willig		(Type, Pri moth			19b. Mailing 1344 C	Address (Stre lay Rd. Sy	et and Num kesville	ber or Ru , MD 2	ral Route Numb 1784	er, City or Tow	n, State,	Zip Code)	
iore, I ges I and it of Healt :: If item other trau		Oa. Method of Disposition		3 Ren	noval from State	crer	natory or oth	tion (Name of co er place) emorial Ga	- 1		Date 05, 2010	20c. Location - Marri	•	Town, State Ile, Mar	
Baltimore, permit. Pages 1 as Department of He, Important: If ite	li	Donation 5 0 Signature of Finera S					22. N	ame snd Addre	ting Farilly	ome, P.	A. e Ellicott Ci				
យ ឱ្យ គឺ ខ្មែ Physician		3a. Part I. Enter the dise	n end	molication	A MOL	293								Approxim	nate Interval
Medical		failure. List only one	cause on	each line.	ine and							.,		Between	Onset and Death
Examiner	ľ	or condition resulting in d	eath)		(or as a conseq										
in the second se		Sequentially list condition f any, leading to immedia cause. Enter Underlying	te Caucu		(or as a conseq	uence of):									
ted Insit Examiner		Disease or injury that init events resulting in death)	tiated Last		(or as a conseq	uence of):									
executian and ial - tra		X UNPENDED		d	NDED a,27, 2	Q _n _f	nor I	M g905	7/21/	10 1	Tr				
3760, ficate be ex g physician s the burial	1 2	F FEMALE: 3b. Was decedent pregna	ant in the		If yes, outcome		icy			pregnan		23d. Date of Month		ay	Year
ords, P.O. Box 687 w requires that the death certific s been signed by the attending I should be detached for use as the ordered by Physician/		past 12 months?	Unkno	4	Pregnant at ti	me of death	_ ==	al death 3 er (Specify)		, pregnan		World		ay	Toda
D. Bc the dea by the a sched fo		Part II. Other significant		"_	Unknown outing to death t	out not resu	Iting in the u	nderlying cause	given in Pa	art I.	23e. Did tob	acco use contr	ibute to	the cause o	of death?
P.C. rres that signed be deta	3										1 Yes	2 No 3	Prob	ably 4 🗸	Unknown
Division of Vital Records, P.O tall or Attending Physician: The law requires that the after death. **A price death.** **A brite death.** **A brite funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in by the funeral director.											24a. Was ar autops	y i	orior to c		ngs available of cause of
tal Recolisian: The law certificate has ector, page 2 sl											perform 1 ✓ Yes 2		death?	s 2	No No
Vital F ysician: his certifi director,	3 3	25. Was case referred to examiner? 1 ✓ Yes 2 ☐ 1		Hospital	1 Inpatient	2 🗸 EF	VOutpatient		Other	-	Home 5 R	Residence 6	Other	:	
n of Virding Physin. After this funeral dir	12	27. Manner of Death	7	28	a. Date of Injury (Month, Day, Yea	/ 28 ar)	Bb. Time of Ir		jury at Work		8d. Describe ho	ow injury occur	ed		<u>.</u>
ision Attendir death. ector: by the f		2 Accident	Pending Investig	ation EC	5/21/1 Be. Place of Inju		d 1000	hrs -	Yes 2X		ink	reat and Numb	er or Ru	ral Route N	lumber City
Division of Vital Records, P.O. Box 68: the Hospital or Alterdation of Vital Records, P.O. Box 68: the Hospital or Attending Physician: The law requires that the death certifinate At hours after death. The Funeral Director: After this certificate has been signed by the attending applicitly filled in by the funeral director, page 2 should be detached for use as inical Certification: To Be Completed by Physician		4 Homicide	Could n determi	ot be		esider		t, lactory, office	- Durraing, Go	5	8f. Location (St or Town, Sta ykesvi]	te)1344 Lle, MD	Jay	Road	idinibol, only
To the Hospital within 24 hours To the Funeral completely fille				ner: On the	the best of my basis of exami anner stated.										
Tail Sign		29b. Signature and title of	f certifier			/_			nse number			29d. Date sign		oth, Day, Ye	ear)
	-	CLAM 30. Name and address of	Derson with	L1	ted cause of do	ath (Item 23		0.0	C.M.E.			June 1, 20	10		
6		Zabiullah Ali, M.I	D. As		Medical Exa		•	n Street, Ba	Itimore, N	MD 212	01				
State Registra		31. Date filed (<i>Month, D</i> ay	(,Year)	กาก	32. Registrar's	s Signature	1	10.0							
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3	Section 201	0	900min page	7	2	3	

		I-For State Registrar			Certific	ate of	Death			Re	eg. No.		
Physiciar Medical Examin	.,	Decedent's Name (First, Middle		cia A	nn Luc	e-Br	own			Date of Deat Month May 28, 20	Day Year		3. Time of Death 0659 hrs
		4a. Facility Name (if not institution 4008 Orchard Road	n, give street and n	umber)		41	o. City, Town, o Baltimore	r Location o	of Death		4c. County o	f Death N/A	
Funeral Director		5. Social Security Number 033 56 1649	6. Sex	,	n yrs. last bir 38	hday) Yrs.	If Under 1 Year Months Day				h(MM/DD/YYYY) L/1971	Foreign	hplace (State or n untry)Maine
ow any	Ī	Usual Residence of Decedent 10a. State 10b. County Maryland N	I/A	10	c. City, Town	or Location							10d. Inside City Limits 1 X Yes 2 No
yland Pe-f sh	흱	10e. Street and Number	1/ A		Dai	CIMOI	10f. Zip Code				og. Citizen of Wha	at Cour	
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	2 	4008 Orchard					212				U.:	S.A.	
imore, MD 21215-0036 Pages I and 2 should be filted within 72 hours after death with the Maryland ment of Health and Mental Hygiene and Internation in marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	by Funeral		1 Yes orced if Yes, Give Ye or Dates:	orces? 2X	No	If Ye	Decedent of Hi s, specify Cuba Yes 2 X No	n, Mexican, specify:	gin? (Spec , Puerto Ri	can, etc.)	- 14. Race - White,	etc.	ite
21215-0036 hould be filed within 72 hours after did Mental Hygiene is marked other than "natural", or titic event, the Medical Examiner min	Completed	15. Decedent's Education (Specific Elementary/Secondary (0-12) 9th		de comple (1-4 or 5+)	eted) 16a.	during mo	s Usual Occupa st of working life				16b. Kind of Bus		
OOC withing giene.	탉	17. Father's Name (First, Middle,	Last)			ноп	emaker	18 Mother	's Name (E	iret Middle N	Maiden Surname)	n Ho	ome
21215-0036 Juld be filed within 7 Mental Hygiene manked other than fice event, the Medical	8 B	19a. Informant's Name/Relationsh	Joseph	n Ric	hfield				Cath	erine l	,	State	Zin Code)
MD 2 nd 2 shou alth and b m 27 is r aumatic		James Cross /			4	008 0	rchard	Avenu	ıe	Balt:		ary]	land 21225
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If liten 27 is marked other tinjury or other traumatic event, the Med		1 Burial 2 X Cremation 4 Donation 5 Other Sp	pecify:	rom State	cremat	ory or other	ematory		06/0		Baltimo	re,	Maryland
Balt permit. Depart Import injury		21. Signature of Funeral Service	ledrie	lae	١	400	Ol Ritc	hie H	ighwa	y Balt	•	lary	P.A. 1and 21225
Physician \/Medical	1	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.								est, shock, or head	t	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as			Jan 9	<u>u urpne</u>	myur	diiziic		110001011		
		Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Cina to (or es :	a consequ	ence of):								
ficate be executed g physician and the burial - transit		events resulting in death) Last	Due to (or as	a consequ	ence of):							- 1	
be exe	I/Medical	X UNPENDED	AMENDED	27.28	8a-f.p	er ME	g904 6	5/18/1	LO TT				
760, ficate be g physici the buri		IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes,	outcome o	of pregnancy						23d. Date of d		
Box 68 e death certif the attending ed for use as	Clar	past 12 months?	I I Live	nant at tim	e of death		Ideath 3 er (Specify)	Ectopic	pregnanc	у	Month	Da	ay Year
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g Phys Rer thi	<u>-</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b.	Time of Inj		Iry at Work	, ,		ow injury occurred		Scene
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	agical	one) 2 Medical Exam	nysician: To the be miner: On the basis and manner:	of examina									
F 2 F 0	Ē	29b. Signature and tille of certifier		7/	most	9	29c. Licens				29d. Date signed		th, Day, Year)
1000	-	30. Name and address of person of	who completed cau	se of deat	h (Item 23a)		O.C.	M.E.	<u>-</u>		May 28, 201	·	
orpend		Victor Weedn MD JD	Assistant Me				nn Street, E	Baltimore	e, MD 21	201			
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Med ∂ Exam	dica nine		4a. Facility Name (if	1	give street and	d number)		-	4b. City	, Town, or	Location	n of Death	1 0 0 110		4c. County	of Death	2.11	
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Datuillore, Marylatha Z1Z13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	1	2	11. Marital Status1 ☐ Never Marri3 ☐ Widowed		ied 1X	Decedent E ed Forces? Yes 2 s, Give or Dates. 4	No	lf	Yes, spe	edent of Hisecify Cubar	n, Mexic	an, Puerto	ecify Yes or No Rican, etc.))-		e - Americ k, White, e Whi	etc.	
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Mich and alth and 27 is r			19a. Informant's Na Jeanette			life			-				al Route Numb e. # 208				^{Code)} D 21054	
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To the within To the	2		29b. Signature and t		1/ s	vier. 10 the L	best of my	Knowledge, d		c. License		te and plac	e, and due to		ate signed	-		
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	tate	3	31. Date filed (Month	, Day, Year)	3	32. Registra	s Signati	ure	10	- Pre	-1-11	~/	my / 1	0010	1	× , /	01/	-

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 tem 5 per 1h g905 7-9-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 04:03AM MORRISON MAY ANTHONY R 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County Hospital Columbia Howard Social Security Numb If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min Country)
Washington DC -84-7589 **Director** Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ¹XXYes 2 □ No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6110 Majors Lane 21045 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married þ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Twelfth Federal Police Officer None Federal Government Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Charles Belt Jacqueline Wiseman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Morrison/Wife 6110 Majors Lane, Columbia MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 66/03/200 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee Donald R. Gray 22. Name and Address of Facility Robert G Mason Funeral Home Inc 1661 Good Hope Rd SE, Washington DC 20020 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MET A BOLIC ACIDOSIS Medical Due to (or as a consequence of) Examiner RENAL ALUTE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): the burial-transit SHOCK dl resulting in death) Last Due to (or as a consequence of): Physician/Medical SEPTIC as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 2 No 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ALCOHOLIC HEPATITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SPONTANGOUS PERITONITIS has autopsy performed? Hospital or Attending Physician: The 2 😾 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending after death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Funeral Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kallemach D006 7127 MAY, 21, 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luciano Amado MD, Howard County General Hospital, 5755 Cedar Lane, Columbia MD 21044 31. Date filed (Month, Day, Year) State 32. Registrar's Signature JUN 03 2010

Registrar DHMH 17 Rev 7/2009

21215-0036

Maryland

Baltimore,

Box 68760

P.0.

Records,

Vital

Division of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Meseke Irvin Nea1 10:354 17117 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Baltimore Washington Medical Center Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birth place (State or Foreign Country) **Funeral** 1**X**XM 2 □ F Months Hours 08/19/1922 Director 215-18-6458 87 MD Usual Residence of Decedent or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must <u>be notified at</u> 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Linthicum MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 Greenwood Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Completed by 1 Never Married 2 Married 1XXYes If Yes, Give 2 No 1 Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Window Installation 12 Installer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Naomi Carol Snyder William E. Meseke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Dawn Jones / granddaughter Akron, Ohio 44312 904 Utica Avenue, Department of Healt Important: If item 2 any injury or other Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2XXCremation 3 Removal from State 05/29/2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Atlantic Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 5 Other (specify) 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ completed filled in by the funeral Manner of Dea h
Natural
Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deat To the Funeral Director: Suicide 3 ☐ Suiciae 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

|D⁺|
State

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Prin

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month May 29 Day 2010 3:41 Patricia Ann Miller ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George Prince George Hospital Center Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan. 18, 1964 . Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 → F Hours Director Yrs 46 219-86-3636 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔯 No MD Prince George Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5618 Whitfield Chapel Road, T2 20706 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🖾 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: 27 is marked other than "natural", traumatic event, the Medical Exa If Yes, Give Specify: white 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Nelson Utterback, Sr. Dorothy Ann Betz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5618 Whitfield Chapel Rd., T2, Lanham, MD 20706 Dennis H. Miller, Sr./Husband injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel Crem. 20c. Location - City or Town, State June 3 1 Burial 2 A Cremation 3 Removal from State Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, 313 Talbott Ave., Laurel, MD 20707 M01053 23a.(P/rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Multiple System Failure Medical resulting in death) Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Bilateral Pneumonia that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Renal Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day 1 ☐ Yes ∠x. 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. β 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed' 2 × No 1 ☐ Yes 2xx No 1 🗌 Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes ပ္ 2 No 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1XXNatural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ceriffier 29d. Date signed (Month, Day, Year)

State Registrar

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

7525 Greenway Center Drive, Suite 211, Greenbelt, MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Willie C. Blair, MD,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sophie D. Malinick 2010 May 5:45 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fernbrook Assisted Living Anne Arundel Odenton 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Hours 1 □ M 2XXF Months Days Min. Director Yrs 063-14-1366 88 Sept. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 🗆 Yes 2 😾 No Laurel MD Prince George's 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8620 Portsmouth Drive 20708 USA items ; 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or 1 ☐ Yes 2 🛛 No If Yes, Give ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10th Homemaker Own HOme Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ bef Frank Ozimek Bertha Kuczma 19a. Informant's Name/Relationship (Type, Print) of Health and item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Marie Simmons/Daughter 8620 Portsmouth Drive, Laurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of F 1 Donation 5 ☐ Other (Specify) Important: If any injury or Arlington National 6/29/2010 Arlington, VA 21. Signature of Funeral Servide Licensee 22. Name and Address of Facility Donaldson Funeral Home, 313 Talbott Avenue, EUNICO Laurel, MD 20707 M01103 23a. Part X. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only on the use on each line.

Immedial Cause (Final disease or condition) Approximate Interval Between Onset and Death Physician/ menti disease or condition resulting in death) 4 tar Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated second Examine Due to (or as a consequence of): that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Dav Year Pregnant at time of death 5 Other (specify) been signed by the s should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 A Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes To the Hospital or Attending Physiciam: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 No Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clarbaly 2106 Alcot uno) 31. Date filed (Month; Day, Year)-

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner icility Name (if not institution, give street and 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE . Social Security Number 053-48-61 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **Y** M 2 □ F Months Hours 1929 QUEBEC, CANADA Director and Mental Hygiene.
and Mental Hygiene.
'is marked other than "natural", or items 23a or 20a.......
'is marked other than "natural", or items 23a or 20a...... 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 21120 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 M No If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEER Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Der artment of Health and Mental Important: If item Z7 is marked any injury or other traumatic ev one. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 MEEWING-WIFE Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 2010 TIMOIJIUM 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee RD. MONKTON, MD 21111 23a. Part 1. Enter the disease, or complications that caused shock, or he let fullure. List only one cause on each line. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cerebra hemorrhag disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ninknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 🗆 Yes Other: 1 primpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Naturai 5 Pending work? 2 No Accident Investigation Could not be 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State, Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) DOO6 429 MAY 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL UKERIMA RAL7 mine VAMSUZD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fb 8904 6-9-10 earth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month MAY Physician Year 21, 2010 9:00A /Medical Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THOMAS MORE NURSING FACILITY HYATTSVILLE, MD PRINCE GEORGE'S 5. Social Security Number 579-76-8599 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **9.56**) (Month, D**1**) **9.56**) 9/27/2010 Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Director WASHINGTON, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "tectral Examiner must be notified at DC WASHINGTON 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 C ST., SE #202 20019 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nranging or other traumating." Elementary/Secondary (0-12) College (1-4or 5+) COOK PRIVATE 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROSEVELT McCOLLUM CATHERINE EVANS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4730 C ST., SE #202 WASHINGTON, D.C. 20019 19a. Informant's Name/Relationship (Type. Print) 4730 C ST., SE #202 WASHINGTON, SYLVIA McCOLLUM/WIFE 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GLENWOOD CEMETERY 5/29/10 WASHINGTON, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAPITOL MORTUARY 21. Signature of Funeral Service Louinsee D.C. 20002 MARYLAND AVE., NE WASHINGTON, 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death omplications that caused the death. Immediate Cause (Final - Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter for u 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 1 ☐ Yes 25 9 ☐ Unknown detached Ö 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, Completed by sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johnnown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate 1 □ Yes (2) this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2/27 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) Certification: To After thi funeral o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation death. 1 🗆 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Cortifying Physician: To the best of my mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1078 4922 LA SALLE RD 30. Name and address of person who completed cause of dath (Item 23a) (Type, Print) DONI 01 20782 HYATTSVILLE, MD. 31. Date filed (Month, Day, 32. Redistra 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 1 per doc 2904 6-22-10 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Kenneth Hagler aka 2. Date of Death Physician/ Month Year TONY L. MATHEWS Day 2010 Medical 1302 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death MONTGOMERY Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE Sex 1 □ M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-98-6601 Days Hours Min. Months 3(MST), DEVOY944 Director 36 WASHINGTON. Lisual Residence of Decedent or 28a-f show a notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MONTGOMERY GAITHERSBURG 1 ☐ Yes 2 ☐ No 10e. Street and Number ral", or items 23a or Examiner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 803 CURRY FORD LANE 20878 UNITED STATES 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X ☐ No Specify: Specify: BLACK "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PASTOR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 KENNETH HAGLER SHARON FALLS 19a. Informant's Name/Relationship (Type, Print) ESSIE LANE /WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 CURRY FORD LANE GAITHERSBURG, MD. 20878 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) LINCOLN CEMETERY 6/5/10 BRENTWOOD, MD 22. Name and Address of Facility CAPITOL MORTUARY Signalura of Funeral Service 1425 MARYLAND AVE., NE WASHINGTON, MD 20002 23a. Part 1. Enter the diseas complications that caused the death. D not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. shock, or heart failure. Immediate Cause (Final Onset and Death Physician CARINII PUEUMONIA disease or condition resulting in death) PNEUMOCYSTIS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Day Year detached g Unknown by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an nas autopsy page 2 performed' certificate ! 2**X** No Yes 2X No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 5 Pending Investigation 2 No Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, MD 26/10. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Prive, Rockville, MO. 20850 BELAY ATNAFU-9901 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **JUN 0 3 2010**

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month MAY WAYNE LESTER MRAZEK 29 2010 10:57 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/29/1947 **Funeral** Birthplace (State or Foreign Country) 360-36-4300 1 ፟ M 2 ☐ F Months Days Director 63 Yrs. Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits GA Haralson Bremen 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 544 Waddell Street 30110 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces or . Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 N 966-68 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Year or DatesUS Army 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Mrazek Elizabeth Bosworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherry Mrazek / Spouse permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce. 544 Waddell Street, Bremen, GA 30110 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Final Journey Crem. 1 Durial 2 K Cremation 3 Removal from State 6/3/2010 Woodbine, MD 4 Donation 5 Other (Specify) Marshall Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Signature of Funeral Service Darota, W. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or finjury that initiated events Examine Due to (or as a consequence of) burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month ed by the a detached f P.O. s been signed by is should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy performed? this certificate 1 X Yes 2 🗆 No 1 Yes 2 No the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 🔲 Yes 2 😾 No Other: 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death of or Attending Paragraphs after death. Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

24 hours a Hospital To the I within 2

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUZANNE GILLERN CAPT MC USA 31. Date filed (Month, Day, Year) 32. Registrar's Signatus rache

3 🗆

JUN 0 3 2010

29b. Signature and title of certifier

only one

06/01/2010 0101241833 (VA) NATIONAL NAVAL MEDICAL CENTER

29d. Date signed (Month, Day, Year)

BETHESDA MD 20889-5600

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 7:00 PM Louise McClain 31 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Woodlands Assisted Living Middle River Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 26, 1921 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 579-32-9818 1 □ M 2 😿 F 88 Director Yrs Kentucky Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, <u>the Medical Examiner must be notified</u> at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Baltimore Middle River 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3523 Bay Drive 21220 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White Specify: 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) own home 2yrs Homemaker Be permit. Page 1 and 2 should be filec.
Department of Health and Mental Hv.
Important: If item 27 is markany injury or other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Oakley Shelby Iris Cherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna Phelps /daughter 3523 Bay Drive Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Docation 5 Other (Specify) Bayview Crematory: 6/1/10 Baltimore MD 21. Sign / v e of Fun val Service Licen 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final Cle Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Łast Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by story 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Certificate: To Other: ALF 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D - 21221. BLUD, WASERM. 709. EASTERN MALIKA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month; Day,-Year)

Registrar's Signature

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PM Gavin James Moran MORAN MA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STAGNES HOSPITAL BALTIMORE **Baltimore City** 900 CATON AVE Birthplace (State or Foreign Country) Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Director MD May 28, 2010 none Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director **Ellicott City** MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, Its Worlden Examiner muttle once. 3126 Nestling Pine Ct. 21042 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant 1)/A infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be **Matthew Paul Moran** Christina Kunkel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3126 Nestling Pine Ct. Ellicott City, MD 21042 Matthew Moran Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 ☐ Other (Specify) Jun 03, 2010 Clarksville, Maryland Columbia Memorial Park 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City. MD 21043 1100531 Approximate Interval Between Onset and Death 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Immy diate Cause (Final disease or condition resulting in death) RESPIRATORY INSUFFICIENCY **Physician** /Medical Due to (or as a consequence of): Examiner ASCITES MASSIVE Secure tidlly list or letters if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □Yes 2 1 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

29c. License number

57

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc g905 7-7-10 vt. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

29d. Date signed (Month, Day, Year)

900 CATON AVE.

BALTIMORE, MD

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ARTURO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANTOS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 09:24 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HARBOR HOSPITA BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/07/1950 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min. 1 M 2 X F 59 West Virginia 220 58 1236 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10h County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, it a Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3820 Fairhaven Avenue 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 页 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2K No Specify: Be Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th Northrup Grumen Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Mallory Cinda Wright ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Trov Amoss / Son 3820 Fairhaven Avenue Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If Ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bluefield, W.V. Grandview Mem. Garden 06/03/2010 22. Name and Address of Facility 21. Signature of Funeral Service License Gonce Funeral Service, P.A. Part 1. Enter the disease, or supplied shock, or heart failure. List only nameroushi 4001 Ritchie Highway Baltimore, Maryland 21225 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ie cause on each line. Immediate Cause (Final **Physician** tastatic adenorancino ma resulting in death) /Medical Due to (or as a consequence of): Examiner piratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Chronic obstruc Palmo rary Box 68760 Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 Other (specify) Pregnant at time of death P.O. □Yes 2□No 9X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

REBECCA WRIGHT

3004 SOUTH HANDVER

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RESDOO

STREET BALTIMORE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Louise J. Madei May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington medical Center Glen Burnie Anne Arunde Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country). Virginia Funeral 1 M 2 X F Months Min. 05/09/1923 87 216 18 9248 Director Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore Marvland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1514 Filbert Street 21226 U.S.A. "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. 3 X Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Homemaker Own Home is marked other Be permit. Page 1 and 2 should be filec. Department of Health and Mental Hv. Important: If item 27 is mariany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Podruchny Sr. Julia Schemenski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Madej / Son 8107 Edgewater Road Baltimore, Maryland 21226 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06/03/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cross Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 mission (af 1. Enter the increase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consecuence of physician and the burlal-trans that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be-hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signe page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' this certificate 2 - No Yes 2 No 25. Was case referred to prédical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending ☐ Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2010.

Registrar

State

30 Name and address of person

31. Date filed (Month, Day, Year)

Tsion Berhane

S

4404 Queenbury Road

Riverdale, Maryland 20737

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Year Barbara Mack 6:20 AM May 29 Medical 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMOME NORTHWEST HOSPITAL RANDALLSTOWN 8. Data & Birth 12-17-1940 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Under 1 □ M 2 F Months Hours Min. 216-36-0593 69 MARYLAND Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No BALTIMORE GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3407 TULSA RD. 21207 USA death 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: BLACK Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PAROLE SUPERVISOR CORRECTIONS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM F. CARTER MARGARET M. BLACKWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 LEAZETTE_BOYLES (DAUGHTER) 3407 TULSA RD. GWYNN OAK, MARYLAND 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot Cren 1 🗌 Burial ation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 6-1-2010 BALTIMORE, MARYLAND of Funeral Service Licensee IONATHAN 21. Signature D. HIBNER^{2. Name and Address of Facility} PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 2121 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, , or heart failure. List only one cause on each line. 23a. Part/ Approximate Interval Betwe shot Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiothrombotic event Medical Due to (or as a consequence of): Examiner cardiovas cular disease atheros clerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has autopsy performed Yes 2. certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🗵 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this : After thi 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work 124 hours after death.

Je Funeral Director: A pleted filled in by the fu 1 Tes 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 115RajapakseMID 5/29/10 DOUS7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-235, Baltimore, MD. 21209 Rajapaks, M.D 2835 Smith Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

Registrar

3. Time of Death 6:55 PM th imore thplace (State or Foreign untry) MD 10d. Inside City Limits 1 Yes 2 No buntry? Prican Indian, e, etc. hite Industry Worked unkn. p Code) s Mills, MD Town, State MD
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM 24a,25 per dr.,g90406/03/2010dhb

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Physician/ 20 TO Leonard Parker 5:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of Queen Annes, Inc. Centreville Queen Annes Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) 12, 1933 77 NC **Director** 216**-**30-6441 May Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes XX No MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code P 10g. Citizen of What Country? Funeral items 23a 7431 Hickory Lane 21076 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Angred Forces? Black, White, etc. 9 δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White "natural", 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed L.C. Parker Fuel Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ Raphael Parker permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Frankie Mae Sparks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Linette Miller/ Daughter 224 Old Line Drive Centreville, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/27/2010 Glen Haven Mem. Park : Glen Burnie, MD uneral Serv 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician, Gruce disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ☐ Pregnant at time of death page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Ves 2 ours after death.

eral Director: After this certificate I filled in by the funeral director, pag 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director. It 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\mathbb{P}\) Other (Specify) 1 🗌 Yes 2 🔀 No HOSPIE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueau occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 2

Registrar

State

(0)

2540

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VILLAY

J EFFREY

10 nni

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 5 1:13 PM **Physician** Norma J Parrish 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** osedale Baltimore ranklin Square Hospital 8. Date of Birth (Month, Day, Under 1 Year | If Under 24 Hrs. (In yrs. last birthday)
74 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 1 F 235-52-2267 VA Aug.1, Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Baltimore Essex MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21221 1036 Foxcroft Lane by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0036 White 1 ☐Yes 2XNo Specify: 3 ☐ Widowed ♣ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Northwest Hospital Mail Clerk 12th 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be Health and Mental and 2 should be Rhoda Barrett Earl Hankins ဂ traumatic Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health.
Important: If item 27 is any injury or cet. 37 Cardinal Drive Hanover PA 17331 /daughter Robin Smith Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 6/2/10 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □ Yes or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attende within 24 hours after death To the Funeral Director: the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Malle Kelly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Balitmore, MD K

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygid Important: If item 27 is marked other if any Injury or other traumatic event, ##

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician

Attending Physician:

Hospital or within 24 hours a To the Funeral I completely filled

after death Director:

in by the

Examine

Physician/Medical

\$

Completed

Be

၉

Certification:

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

1 🔲 Inpatient 28a. Date of Injury (Month, Day Year)

and manner stated.

2 ER/Outpatient 3 □ DOA 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

livingsta N/H 101 ft WASKigt

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 05-12-2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

icHAE 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 26 Day 20°10 7:50 рм Naomi Lorraine Roth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD 8. Date of Birth **Funeral** 1 □ M 2 🕇 F Days Hours Min. NOV . 17 . 1917 Months 92 Yrs Director 220-38-2283 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director MD Prince George Laurel 1 ☐ Yes 2 🎦 No 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 15316 Bond Mill Road USA 20707 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo 11 Marital Status 14. Race - American Indian. Black, White, etc "natural", or δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes. Give Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Office File Clerk Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman L. Wilson Ruth Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Norman E. Roth/ Son 3512 Reynard Dr., Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛂 Burial 2 🗌 Cremation 3 🗌 Removal from State May 2010 Burtonsville, MD 4 Donation 5 Other (Specify) Union Cemetery 22. Name and Address of Facility Donaldson Funeral Home, P.A. Signature of Funeral Service Licensee M01053 313 Talbott Ave., Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Complications Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Janian Cana Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death ed by the a detached f 1 Yes 2 kg 9 Unknown signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X N this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 | No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛛 Other (Specify) Hospia 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 1 Yes 2 No at home, unwitnessed April 27, 2010 Investigation UNKnown 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hone Reynard St, Ethicolt Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CRN? R149194 may 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21204 6701 Nr Charles Towson,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Claude E. Rossignol 18/1 Ma Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Square ROSE Franklin tOSD 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (I **Funeral** 1 X M 2 □ F Months Days Hours Min. (Month, Day, Year, unk. Director 69 1941 anuary 4. Maine Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Baltimore Maryland Rosedale 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country? United States Funeral 1315 Chesaco Avenue Apt. 112 21237 of America permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ white 1 Yes 2X No Specify: Maryland 21215-003 If Yes, Give Completed 3 Widowed 4 K Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Albert Rossignol, Sr. Azelda Fongamie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 G Oak Leaf Circle Abingdon, Maryland 21009 Claudia M. Vega/ daughter Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State June Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evans Funeral Chapel Forest Hill, Maryland 2010 21. Signature of Fundal Service Licens Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): arres Medical resulting in death) Examiner Atheroscleratio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury Diabetis Mellitus that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Ovesit Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Hyperlipidemia, depression 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☑ No Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date sighed (Month, Day, Year) D69540 31/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swite 204 Parkville MD 21234. Jan MD8813 Waltham 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 1 2010 1:40A Mildred L. Schelhaus Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min, 8. Date of Birth (Month, Day, June 21 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) Months 1 □ M 2X□ F ,1922 Mary Land Director June 217-14-5949 Usual Residence of Decedent ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-dical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural". An isome 500 An 100 An 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Director 1 Yes 2 No Balto. Nottingham Md. 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3800 Meghan Drive USA Unit 3C 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 White 1 Yes No Specify Completed 3 ₩ Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Clerk Bank 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Sarah Magness Harry Lehnhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21236 Nottingham, Md. Son 3800 Meghan Drive Unit3C William H. Schelhaus injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or of Page 1 1 🌠 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Gardens of Faith 6-4-2010 Balto. Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician least disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and if for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 1 Yes 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2**X** No Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural. work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death

To the Funeral Director ≠
completed filled in by the Accident Investigation Suicide
Homicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one re and title of certif Name and address of person who complete cause of death (Item 23a) (Type, Print) HARLES ST. BATIMORE

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25tate of Maryland 40,000 trace 200 dealth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SCHNEIDER GRACE ALINE MAY T6 20TO 9:45A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9315 BILLINGSLEY ROAD CHARLES WHITE PLAINS Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 1) 1 □ M 2 🛣 Months Davs Hours Min. Director 213-40-9323 90 MARYLAND MAR 1920 Usual Residence of Decedent 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits WHITE PLAINS MD CHARLES 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9315 BILLINGSLEY ROAD 20695 S. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates WHITE Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) event, the 8 HOUSEWIFE OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROLAND EARL HAMILTON ETHEL HAMILTON ROBEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau GEORGE SCHNEIDER JR./SPOUSE 9315 BILLINGSLEY RD.WHITE PLAINS, MD 20695 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXSurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) TRINITY MEM.GDNS. 21,2010 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 any ir 02 M00641 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CONGC 14 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Day Yes 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ,О. Completed by Records, F 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ûnknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsv perform death? 1 🗌 Yes 2 🔲 No ☐ Yes Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? မ 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this. 28a. Date of injury (Month, Day, Year) 27. Manner of Dea Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 Tes 2 🗌 No s after death Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practionars To the best of my knowledge at the time, date and place, and due to the cause(e) and mainly as stated 29d. Date signed (Month, Day Year) 77/2010 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN

3

32. Registrar's Signature

10-04051 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Yolanda Sydnor State of Maryland / Department of Health and Mental Hygiene 2010 17257 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 27, 2010 Medical Examiner 1140 hrs Yoland<u>a Sydnor</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Bon Secour Hospital Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign 218-82-1394 Director Months Days 41 11/25/68 $_2X_F$ 1 M CountryMD Usual Residence of Decedent any 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. MD N/A Baltimore 1 X Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1538 Winford Rd USA 21239 Funeral 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? African 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: American ğ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Social Worker Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Archie Sydnor Be Bertha Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Sydnor/Brother 1538 Winford Rd, Balt., MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Balt., MD 6/3/10 Bayview Crematory Donation 51 Other Specify 22. Name and Address of Facility Hari P 21. Signature of Funeral Service Licen Close F.Svs 5126 Belair Rd, Baltimore, MD Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Cardiac arrhythmia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Right ventricular dilatation & chemical disturbance Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Protein S deficiency and diabetes (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. cal UNPENDED the attending physician ed for use as the burial -AMENDED ine a-b, PII,27 per ME g905 7/15/10 TT Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Hypertension, hypothyroidism Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? page this certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Other4 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Director: 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 28, 2010 who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar *2*010

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John A. Signore 2010 9:20P May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Hospice Timonium Baltimore County 8. Date of Birth
(Month, Day, Year)

April 18, 1931 Ambler, PA 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 XM 2 | F Months Days Hours 181-24-2470 Director 79 Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director Maryland Harford County Aberdeen 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4907 Bristle Cone Circle United States 21001 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify White Specify: 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative 12 02 Manufacturing Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Signore Philomena Liberto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4907 Bristle Cone Circle Aberdeen, Maryland Anna Marie Coble (Sister) 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State (Montegomery Co.) St.Stanislaus Cem. 4 Donation 5 Other (Specify) June 05,2010 Lansdale, Pennsylvania Signature of Funeral Service Lice Gefficey J. 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093-2215 Gair, Sr. 23a. Ray 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) END STAGE RENAL DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal deal Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2X No death? Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending I Director: A 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be within 24 hours after de To the Funeral Directo completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

p.m.

0107

SIGNORE

DHMH 17 Rev 7/2009

State

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JENNIFER HAUF,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Edmund Louis Smialkowski Vear 712 Medical UNE 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore City N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F 81 Yrs. Days Hours 214-24-8298 9/15/1928 Balt. Maryland Director Usual Residence of Decedent 28a-f shov 10b County 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Baltimore Baltimore City 1 XYes 2 No 10e Street and Number 10f. Zip Code 5 10g. Citizen of What Country? United States must be 23a Funeral 6401 Loch Raven Blvd. 21239 America items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working alth and Mental Hygiene.
27 is marked other than "r r traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) electronic engineer A.A.I. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Albina Drozd Stephen Smialkowski permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John J. Smialkowski, Sr., 130 Greenmeadow Drive Timonium, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.A. Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary 30 years cate disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 has autopsy performed certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ပ္ Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No iniury Natural 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completed filled in by the fu death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier 1/🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2438946 Dune 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vision Memorral Louis E. Kovacs

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Righstrar's Signature Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrer		partment of Health and I e <i>rtificate of Death</i>	Mental Hygien	(1111) 1//61
	Physici		1. Decedent's Name (First, Middle, Last) F. C.C. S.M. ith	1		pm ,	3. Time of Death 1:33 p M
	/Medic Examir		4a. Facility Name (If not institution, give street Glady's Spellman	and number)	4b. City, Town, or Location of Death Cheverly, N	1 40	c. County of Death Prince Georges
	Funeral Director		5. Social Security Number 6. Sex 1213-96-0004	7. Age (In yrs. last birthda 45	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year May 17, 1	9. Birthplace (State or Foreign Country) 965 Md.
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Md. Prince Georg	10c. City, Town or	Location Capital Heights		10d. Inside City Limits 1½∏Yes 2 ☐ No
	with the	Director	10e. Street and Number 905 Kayak Ave.		10f. Zip Code 20743		itizen of What Country?
36	72 hours after deeth with the Maryland Inatural, or Heme 23e or 28e-f show dical Examinar must be modified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 12. W	Yes 2 No Yes, Give X	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		United States 14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	within 72 hours affiliene. then. 'then "natural', or tre Medical Exerti	Completed b	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) (Gi	cedent's Usual Occupation ve kind of work done during most of work to DO NOT use retired)		Kind of Business/Industry
Maryland 21	al Hygial Lother	To Be Cor	12th 17. Father's Name (First, Middle, Last) Raymond Smith			ne (First, Middle, Maide	
lary	2 should be and Mentis is marked eumatic e	-	19a. Informant's Name/Relationship (Type, Pr	rint) 19b. Ma	iling Address (Street and Number or Ru	rbara Jones ral Route Number, City	
altimore, N	Pages 1 and 3 nent of Health int: If Item 27 iry or other tr		Robin Ham-Smith/ Wif 20a. Method of Disposition 1 Burial 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	20b. Place of Discometery, c	position (Name of rematory or other place)	Date 20c. I	hts, Md. 20743 Location - City or Town, State
Baltir	permit. Pag Depertment Important: I any injury o		21. Signatul of Funeral Service Censee	121 /200	22 Name and Address of Escility	apitol Mort	_
	Physician		23a. Part . Enter the disease, o complication shock, or heart failure. Lis only one caulmmediate Cause (Final disease or condition resulting in death)	s that caused the death. If not e			Approximate Interval Between Onset and Death
8760,	Medical Examiner sicien end parial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequence of): Encephal Due to (or as a consequence of):	pathy	2	
P.O. Box 687	ne death certificate the attending phy: hed for use as the	Physician/Medical	in the past 12 months?		3 ⊟Ectopic pregnancy 5 ⊟ Other (specify)		23d. Date of delivery Month Day Year
	quires that the signed by and be detacted	Þ	Part II. Other significant conditions contribut	ing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Il Records,		Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	al: 1 ☐ Inpatient 2 ☐ ER/Outpat	Othor	th (Check only one)	6 Other (Specific)
	Alter fune	atlon: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at	28d. Describe how inj	
Division	P dig ∈	Certification:	3 Suicide 6 Could not be determined 280	e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	ne Hospital 124 hours e ne Funeral I	Medical	(Check only 2 Medical Examiner: C	: To the best of my knowledge, de In the basis of examination and/or and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause(rred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0. /	29c. License number		ate signed (Month, Day, Year)
,	d		30. Name and address of person who complete	ed cause of death (Item 23a) (Typ	DO1850 QUEENShung &	1 m	1 my 9 2010
	P		PAVLA. DEVO,	CE MD 4233 32. Registrar's Signature	QUEENSYUNG F	Pel Hypits	ville 412 20781
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 3 2016	oz. Registrar s Signature	parled		

DHMH 17 Rev 1/2001

State Registrar

YACI 31. Date filed (Month, Day, Year) JUN 0 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 N. EUTAW ST. SUITE 301 BALTIMORE MD ZIZO 32. Registrar's Signature

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	_	For State Registrar	State o				te of L		IVICI		Reg. No.			
		1. Decedent's Name (First, Mide				_			2.	Date of Dea Month	ith Day	Year	3. Time of	f Death
ysicia Medic		WILLIAM	SHIFF	LETT					r	NAY		2010	13:16	
amin		4a. Facility Name (If not instituti	on, give street and nu	mber)		4b. City	, Town, or	Location of Dea	ath		4c. Cou	nty of Death		
	ш	Howard (County Genera	l Hospital				Columb	ia			Н	oward	
eral		5. Social Security Number	6. Sex	7. Age (in yrs.	last birthday)	If Unde	er 1 Year Days	If Under 24 Hr Hours Mir	rs. 8	Date of Birtl (Month, Day	Year)		place (State o	or Fore
ctor		226.18.2844	1 M 2 □ F	9	O Yrs.	Worth	Dayo	Trouis IVIII						VA
		Usual Residence of Decedent		10n Cil	h. Town or Lo	estion				IVIAY	23, 1920		104 1=44= 0	
dat	<u>.</u>	10a. State 10b. Count	ty	100.01	ty, Town or Lo	cation							10d. Inside C 1 ∐Yes	
tifie	cto	MD	Howard					Ellicott (City					-7
oe uc	Director	10e. Street and Number				10f. Z	ip Code				10g. Citizen o	of What Cou	ntry?	
ust	ra	4925 Orchard Driv						21043				U.S		
er m	Funeral	11. Marital Status	Armed Fo		l.S. 13. 1	Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin? n, Mexican, Pue	(Specify erto Ric	/ Yes or No- an, etc.)		Race - Americ Black, White,		
amin		1 Never Married 2 Ma	If Yes, Gi	ve		1 ☐ Yes	2 X No	Specify:			Spe	cify:	- 1	
<u>ä</u>	d by	3 Widowed 4 Divorce		ates:	10. 5				_		101 101 1	wn	ulo_	
dica	Completed	(Specify only high	ent's Education nest grade completed)		16a. Dece	kind of w	uai Occupa ork done a use retired	lurina most of w	orking		16b. Kind of	f Business/In	dustry	
e Me	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	ille.	DO NOT	,							
ŧ,		6	- / 4				_forklif	t operator 18. Mother's N		irot Middle	Maidan Curr	pape	r_mill	
ever	Be	17. Father's Name (First, Middle	·					16. Mother S N	ame (r.	rst, wildale,	ivialueri Suri	iame)		
atic	၉			. Shifflett							Rosa Sh			
raum		19a. Informant's Name/Relation	nship (Type. Print)		19b. Mailir	ng Addres	ss (Street a	and Number or	Rural R	oute Numbe	er, City or Tou	vn, State, Zip	o Code)	
other traumatic event, the Medical Examiner must be notified at		Wayne Shifflett	son	laa.				Aveņue S	-					
or othe		20a. Method of Disposition № Burial 2 ☐ Cremation	a 3 □ Removal from		Place of Dispo cemetery, crei	osition (Na matory of	ame of other plac	e)	Date	'	20c. Locatio	on - City or To	own, State	
		4 □Donation 5 □ Other		I .	rest Lawn	Memo	rial Gar	dens Ju	un 03	, 2010	Mai	rriottsvil	le. Marvi	land
any injury once.		21. Signature of Funeral Service	ce Licen e			2. Name	and Addres	s of Facility					Š .	
E 2		Columnia	- Selet	M0053	5	5	Black Fu	neral Home Columbia	e, P.A	Elliaatt O	ite BAD O	4040		
9		23a. Fart1. Enter the disease, shock, or heart failure. Li	or complications that	aused the deal	th. Do not ent	ter the mo	ode of dyin	g, such as card	iac or re	espiratory ar	rest,	1043	Approximatinterval Bet	te
ian		Immediate Cause (Final		CARDI	INI IN	FARCT	ION						Onset and	Death
cal		distase or condition resulting in death)	a.	(or as a consec									2211	1112
ner				NARY F		SISTAS	E						YEARS	ž.
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consec										
	Examiner	Cause (Disease or injury that initiated events	1-1×P6	RAENSION									YEARS	i.
	Exa	resulting in death) Last	C	(or as a consec	quence of):									
	dical													
- 0	edic		0.											
300	2	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregn							23d.	Date of deliv	erv	
Tor use as	ciai	in the past 12 months?		oirth 2□Feta nant at time of a		⊒Ectopic ⊒Other (pregnancy specify)				1	Month	-	Year
	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9□Unkn			•	-/-							
		Part II. Other significant condi	itions contributing to d	eath but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use c	ontribute to t	the cause of	death'
≀ I	d by									1 🗆 \	′es 2 □ No	o 3 ☐ Pro	bably 4	Unkno
anionia i	ete								- 1	04- 14/	04	th 18/2-2 214	fin din	
N	Completed								-	24a. Was autop	SV	prior to co death?	opsy findings ompletion of c	cause
g	S									1⊡ Yes	rmed? 2 No	1 ☐ Yes	2 🗷 No	
director,	Be	25. Was case referred to medic examiner?					Oth	26. Place of D	eath (C	heck only o	ne)			
Ē	ျှ	1 Yes 2 No			ER/Outpatier			4 LI Nursing			dence 6 □		ify)	
Ě		27. Manner of Death 1 Natural 5 Pend	28a. Date ding (Mor	of Injury th, Day Year)	28b. Time o Injury		28c. Injury Work		280	. Describe h	now injury oc	curred		
5	Certification:	2 ☐ Accident inves	stigation			M		Yes 2 □ No						
7	ij		rmined 200. Place	of injury - At h ing, etc. (Speci	ome, farm, str fy)	reet, facto	ory, office		28f.	Location (S City or Tou	Street and Nu vn, State)	ımber or Rur	al Route Nur	nber,
1	ë		21/											
			ying Physician: To the al Examiner: On the b											(s)
completely filled in by the funeral d	Medical	one)		ner stated.	adon and/of III	. , conyall	, iiiy 0	punon, death of	Journed	at the tille,	adio dila pidi	oo, and due	ine oduse((0)
3	Ž	29b. Signature and title of certif	fier			2	9c. License				29d. Date siç			
		1/1/400	100				HO (6481			MAY.	, 30,	2010	
	-	30. Name and address of person	on who completed cau	se of death (Ite	m 23a) (Type	Print)					/			
	- 1													
v		-	ON CEUY, DO	5753	CEONR	LANE	, (000	MBIA ALD	210	744				

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ORIGINAL

10-04099 George Tyler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		17	1 7	1726

		1- For State Certific Registrar	cate of Death	Re	eg. No.	
Physici		Decedent's Name (First, Middle,Last)		Date of Deat Month	Day Year	3. Time of Death 1843 hrs
edical Exam	ıner	George Thomas Tyler III 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	May 29, 20	010 4c. County of Dea	
•		Union Memorial Hospital	Baltimore	2111	The County of Dod	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last by	pirthday) If Under 1 Year If Under 24	Irs. 8. Date of Birt	th(MM/DD/YYYY) 9. B	irthplace (State or
Director		216-34-6744 1XM 2DF	76 Yrs. Months Days Hours M	12/04/	/1933 Fore	ign South ountry) Carolina
	0	Usual Residence of Decedent	, , , , , , , , , , , , , , , , , , , ,			
any		10a. State 10b. County 10c. City, Tov	vn or Location			10d. Inside City Limits
and show	or	Maryland Baltimore Ba	ltimore	,		1 XX Yes 2 No
Maryl: 28a-f 1 at o	Director	10e. Street and Number	10f. Zip Code	10	og. Citizen of What Co	untry?
3aor		4201 Greenway	21218		United St	ates
th with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 		- 14. Race - Ame White, etc.	erican Indian, Black,
or it	Τ̈́	3 Widowed 4 Divorced If Yes, Give Year 1957-67	4 Ver 2 all appeirs		Specify: Who	1+0
rs afte ural", mine	by	3 Widowed 4 Divorced If Yes, Give Year 1957-67 15 Decedent's Education (Specify only highest grade completed) 16	1 Yes 2 X No specify: a. Decedent's Usual Occupation (Give kind	of work done	16b. Kind of Business	
2 hou "nat	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use			
036 ithin 7 ne. r thar	Jdu	5+	Attorney		Law Prac	ctice
5-0 led w Hygie othe		17. Father's Name (First, Middle, Last)		me (First, Middle, N	Maiden Surname)	
121 d be fi ental arked	Be	George Thomas Tyler	Wathen			7 0 1)
D 2 should and M	욘	19a. Informant's Name/Relationship (Type, Print) George T. Tyler IV / Son	19b. Mailing Address (Street and Number of 4201 Greenway, Balt			le, Zip Code)
and 2 ealth tem 2 traum		20a. Method of Disposition 20b. Place		Date ne 4,	20c. Location - City of	or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti. If tien 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	li I	T X Burial 2 Cremation 3 X Removal from State		ne 4, 2010	Winchester	r, Virginia
Itim it. Pa rtmen prtant		4 Donation 5 Other Specify: ITC . I	Hebron Cemetery			
Ba perm Depa Imp		197/2	22 Name and Address of Facility Resthaven Funeral 9501 Catoctin Mou	Services ntain Hwy	s, Skkot Co v. Frederic	ody P.A.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.				Approximate Interval Between Onset and
Medical Examiner	ř a	Immediate Cause (Final disease a. Atherosclerotic Cardiovasc	cular Disease			Death
Lxammer		or condition resulting in death) Due to (or as a consequence of):				
	<u>-</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				-
	Examiner	Course Enter Underlying Cause C.				
ed nsit	EX	events resulting in death) Last Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit	/Medical	UNPENDED AMENDED				-
50, te be o	led.	IF FEMALE: 23c. If yes, outcome of pregnant		-	23d. Date of delive	rv
3876 rtificati ing phy as the		23b Was decedent pregnant in the	2 Fetal death 3 Ectopic pre	gnancy	Month	Day Year
Box 68760, e death certificate be the attending physical for use as the but	sici	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			
the de	Physician	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
of Vital Records, P.O. Box 68' ing Physician: The law requires that the death certificate has been signed by the attending tuneral director, page 2 should be detached for use as	_≥			1 Yes	2 No 3 Pr	obably 4 Unknown
ds, equire een si ould b	Completed		-	24a. Was a		nutopsy findings available
COF	츁			autop perfor	med? death?	
Re: The		25. Was case referred to medical	26.Place of Death (Che	1 Yes	2 No 1 🗸	fes 2 No
/ital siciar is cert lirecto	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VER	100-		Residence 6 Oth	er:
Division of Vital Records, P. rat or Attending Physician: The law requires the staten death. The Intercor: After this certificate has been signed in by the funeral director, page 2 should be do	-	27 Manner of Death 28a Date of Injury 28	b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
	텵	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
Divisior pital or Attend ours after death reral Director: filled in by the	≝	3 Suicide 6 Could not be 28e. Place of Injury - At home	farm, street, factory, office building, etc.	28f. Location (S or Town, S		Rural Route Number, City
DIVIS Sepital or A hours after meral Dire	Certification:	4 Homicide determined (Specify)				
			death occurred at the time, date and place, a	and due to the caus	e(s) and manner as sta and place, and due to	ated. the cause(s)
To the Ho within 24 I To the Fu completely	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (M	
	2	1/0 = A 1 A 10	O.C.M.E.		May 30, 2010	
V		30. Name and address of person who completed cause of death (Item 23)			, ==, ==,	
111/		Margarita Korell MD. Assistant Medical Examiner	111 Penn Street, Baltimore, M	D 21201		
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	tate	31. Date filed (Month, Day Year) 32. Registrar's Signature				
Regis		JUN 0 3 2010 Denus B. A.	ELEC			

0-04157			e or Print in B						gible.	
Owen Z Thornto	n		ate of Maryland				Mental H	ygiene	201	0 1726
		1- For State Registrar		Cer	tificate of	Death			eg. No.	
Physicia		Decedent's Name (First, Middle	2122					Date of Dea Month	th Day Year	3. Time of Death 1500 hrs
Medical Exami	ner	Owen Z. Tho 4a. Facility Name (if not institution	omton		14	City Town and	andian of Dark	May 31, 2		
		3920 Bareva Road	i, give street and number	,	44.	. City, Town, or Le Baltimore	ocation or Death		4c. County of De	/a
Funeral			6. Sex 7. As	ge (In yrs. Ia	est hirthday)	If Under 1 Year	If Under 24Hrs	8 Date of Bir	th(MM/DD/YYYY) 9.	
Director		218–20–7841			~	Months Days	Hours Min.		Fo	reign
		Usual Residence of Decedent	1XM 2F		90 Yrs.			3-11-1	920	Country) VA
any		10a. State 10b. County		10c. City,	Town or Locatio	n				10d. Inside City Limits
<u>*</u>	_	MD n,	⁄a		Baltimo	re				1 XYes 2 No
Maryland 28a-f show	9	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	Country?
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.	Director	3920 Bareva Road				2	1215		USA	1
with t		11. Marital Status	12. Was Deceden	t Ever in U.S	S. 13. Was	Decedent of Hispa	anic Origin? (Sp	ecify Yes or No	- 14. Race - An	nerican Indian, Black,
leath r item	Funeral	1 Never Married 2 Ma		? No	If Yes	, specify Cuban, I	Mexican, Puerto	Rican, etc.)	White, etc	3.
ifter o	by F	3 Widowed 4 Divo	orced If Yes, Give Year		1 🗌 🕥	es 2 No	specify:		Specify:	African-America
5-0036 led within 72 hours af Hygiene. other than "natural the Medical Examin	b d	15. Decedent's Education (Spec	ify only highest grade co	mpleted)		Usual Occupatio t of working life. D			16b. Kind of Busine	
7, , -	ete	Elementary/Secondary (0-12)	College (1-4 or	5+)	Foreman	t of working life. L	JO NOT use rem	(eu)	Saul Tig	ht Company
15-003(filed within I Hygiene. d other tha	Completed	8th			TOLGIELL					
filed Hyg		17. Father's Name (First, Middle, Emmanuel Thornto							Maiden Surname)	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	19a. Informant's Name/Relationsh			10h Mailing	Address (Street	Georgian T	hampson	nber, City or Town, St	nto Zin Code)
Sho sho	F	Vanessa B. Ellis				d Spring G				ate, Zip Code)
ore, MD set I and 2 show of Health and I from 27 is no her traumatic		20a. Method of Disposition	Niece	20b. P	lace of Dispositi	on (Name of ceme	eterv.	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If itel		1 Burial 2 Cremation	3 Removal from St	ate Gar	rematory or other	r place) est Vetera	ns 6-7-	-2010	Owings Mill	s. MD
ti. Pa	_	4 Donation 5 Other Sp. 21. Signature of Funeral Service I		4					O	
Baltimore, M pemit. Pages and 2 Department of Health Important: If item 2 injury or other traun	Ì	KOONON	HI like	1001		LibertyRo				f Balto. Co.
Physician	\dashv	23a. Part. Enter the disease, or o		the death.						Approximate Interval
/Medi al	H	failure. List only one cause of	on each line. (/ a. Atherosclerotic	Cardiova	scular Dise	150				Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons							
		Sequentially list conditions,	b							
	<u>=</u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of)	i.					
	Examine	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of)	:			•••		-
Ox 68760, eath certificate be executed attending physician and for use as the burial - transi			d							
e execian s	dical	UNPENDED	AMENDED							
760 cate the physic	8	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	me of pregn	ancy				23d. Date of deliv	very
68 certifi se as	lä.	past 12 months?	I CIVE DIIGI	time of dea	th - =	death 3	Ectopic pregna	ncy	Month	Day Year
Box 68760, e death certificate be the attending physic ed for use as the buri	Physician/Medi	1 Yes 2 No 9 Unkr	· 🗀		5 Othe	(Specify)			i .	
O. Bo at the de 1 by the tached f		Part II. Other significant condition	ons contributing to deat	h but not res	sulting in the und	lerlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
P.O.	å P							1 Yes	2 No 3 P	robably 4 🗸 Unknown
ords	ete							24a. Was a		autopsy findings available
e law	Completed							autops	med? death	
tal Rec		25. Was case referred to medical	1			26 Place of	f Death (Check o		2 No 1	Yes 2 No
Division of Vital Records, talor Attending Physician: The law requir rs after death. In Director: After this certificate has been sited in by the funeral director; page 2 should the funeral director and the funeral director	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 E	ER/Outpatient		·		Residence 6 🗸 Ot	her; Scene
ing Phy	-	27. Manner of Death	28a. Date of Inju	ıry :	28b. Time of Inju	ry 28c. Injury	at Work?	28d. Describe h	low injury occurred	
fon tendin eath. ior: A	흵	1 Natural 5 Pendi		ear)		1 Yes	s 2 No			
ivision or Atteno after death Director:	밀	2 Accident Invest 3 Suicide 6 Could		jury - At hor	me, farm, street,	factory, office buil	ding, etc.			Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built	Certification:	4 Homicide					Į	or Town, St	tate)	
To the Hospital within 24 hours To the Funeral completely filled			vsician: To the best of m							
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exam	iner: On the basis of exa	mination and	d/or investigation	n, in my opinion, d	leath occurred at	the time, date a	and place, and due to	the cause(s)
F > F 3	ž	29b Signature and title of certifier				29c. License r	number		29d. Date signed (f	Month, Day, Year)
	- 1	Samuele	MD			O.C.M.	.E.		June 1, 2010	
	1	30. Name and address of person v								
			sistant Medical Ex			treet, Baltimo	ore, MD 2120	01		
	-11-	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	A home	Kel				
Regist		JUN 0 3	SOID House	m 1	9					
DHMH 17 Rev 1/20 OCME 2006	001	NAME			ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 2010 MIGUEL URRUTIA 1845 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST MONTGOMERY HOSPITAL TAKOMA PARK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 3 / 19 1 19 Yaar 579-19-9346 68 Yrs SALVADOR Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20002 HISPANIC 645 H ST., NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. 1 Never Married 2 X Married 1 Xyes 2 No Specify: SALVADORIAN Specify: HISPANIC If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 LABORER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ISABEL RODRIGUEZ ROSA URRUTIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA URRUITA/ NIECE SOUTH FLORIDA ST ARLINGTON. VA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREM 5/19/10 BELTSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CAPITOL MORTUARY re Funeral Service Lice MARYLAND AVE. 20002 NE WASH 23a. Part 1. Enter the disease omplications that caused the death. Do n Inter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between . or shock, or heart failure. L Immediate Cause (Final Onset and Death disease or condition Week Due to (or as a co Se Due to (or as a c Due to (or as a consequence of):

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

DC

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at

of Health and Mental of Health and Mental

permit. Page 1 a Department of H Important: If ite any injury or ot

other traumatic

Maryland 21215-0036

Baltimore,

Box 68760

P.O. |

Records,

Division of Vital

attending physician and I for use as the burial-transi signed by the a cate has page 2 s After this certificate filled in by the funeral director, death.

Examine Physician/Medical þ Completed Be မ

Certificate:

Hospital or Attending Physician: The law 24 hours after deat e Funeral Director: completed within 2

resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) ☐ Pregnant ☐ Unknown 1 | Yes 2L 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24a Was an autopsy perforn 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{\text{Nursing Home}}} \) Nursing Home \(5 \text{\text{\text{\text{\text{Pesidence}}}} \) Residence \(6 \text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{Other:}}}}}}} 2 No 1 🗌 Yes 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

29d. Date signed (Month, Day, Year)

23d. Date of delivery

Dav

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Year

Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7610 CARROLL AVEN STE340 | TAKAMAPALK / MD 20912 MOBALAK 12302 LM

31. Date filed (Month, Day, Year)

only one)

3 🗌

State Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 29, May Robert J. Walsh, Jr. 2010 00:15 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air Birthplace (State or Foreign Country)
 PA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct. 23, 19 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1√XM 2□ F 200-16-2628 83 Oct. 1926 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 ☐ Yes ZXX Director MD Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 424 Gilmor Road 21085 US Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1—Yes 2 □ No 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Jo. 1 ☐ Yes 2 No White Maryland 21215-0036 If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. is marked other than Intelligence Officer U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert J. Walsh, Sr. Irene Walsh ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other tra once. Robert J. Walsh, III (son) 424 Gilmor Road, Joppa, MD 21085 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 09-21-2010 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 22. Name and Address of FacilitySchimunek Funeral Home of Bel Air 21. Signatura of Funeral Service Licensee 610 W. MacPhail Rd., Bel Air, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** possible Aspiration disease or condition resulting in death) /Medical Dif to (or as a consequence of): Examiner Advance COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of). Respiratory Failure Chronic that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Pulmenou the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Cerebrovascular 1 ☐ Yes 2 ☐ No 1 □ Yes Division of Vital I or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500, UPPER CESAPEAKE DR BELAIR, MD 21214, NASRIN J. HUD

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MD

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5129110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 35 AM Medical 4a. Facility Name (if not institution, give Location of Death County of Death **Examiner** Baltimore Istown Age (In vrs. last birthday Under 1 Year If Under **Funeral** 8 Date of Birth 9 Birthplace (State or Foreign (Month, Day, 1 1 2 F Days Min Year Director 220-78-1829 50 MARYLAND APRIL Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 🗌 Yes 2 🗓 No MARYLAND BALTIMORE WOODSTOCK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13 PARK VISTA CT. 21163 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XXNo Specify Specify: BLACK "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade ELECTRONIC TECH STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | marked မ LLOYD H. WILSON BARBARA GILLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Health (13 PARK VISTA CT., WOODSTOCK, Cheryl L. Wilson/Wife MD., 21163 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or o ō 5 Other (Specify KING MEMORIAL PARK 06-05-10 4 Donation BALTIMORE, MARYLAND Signature of Fungra/Service Lic WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part : into the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Cause (Disease or iinjury that initiated events resulting in death) Last betes attending physician for use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 □ No မ 1 Inpatient 2X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Pl 24 hours after death. Funeral Director, After th Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. v one) 29b. Si nature an 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) EVERETTE DARR LAFON, MD. 5401 OLD COURT RD, RANDALLSTOWN, 21133

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 03 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Yea Dorothy Besse1 Wilkerson Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brightview Hospice Catonsville Baltimore **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 😾 Hours Min (Month, Day, 220-20-2669 97 Country) Maryland Director Sept 1912 Usual Residence of Decedent Fshov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1218 0akland Terrace Road 21227 USA 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ģ 1 Yes 2 No Baltimore, Maryland 21215-0036 3 X Widowed 4 □ Divorced 1 ☐ Yes 2 ☐ No Specify: Completed Specify: white Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher/Principal Balt. City School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessel George Caroline Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Bruchey-niece 1218 Oakland Terrace Rd. Halethorpe MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) June 3,2010 Baltimore MD Park Cemetery 21. Sign dur of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home Inc. aline <u>Sulphur Spring Road Arbutus MD</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. INEUMONIA disease or condition Medical resulting in death) (or as a consequence of) Examiner Obstruenos n/Hanse 755052 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live retail usa.

Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year page 2 should be detached been signed by the ☐ Unknown 9 🗌 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ SMENTIA Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate is performed 2 🗌 No Yes 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital A 58 572 A 2 🖪 No 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29c. License number KO88852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day, Year,

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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland portant of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Marr 3 Widowed		Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		l lf	/as Decedent of H Yes, specify Cuba	an, Mexica	ın, Puerto F	Rican, etc.)		14. Race - Ame Black, Whit Specify:		erica
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6876 sertificat iding ph	/Mec	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	of pregnance	су					1/2	23d. Date of de	livon	
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Phy			ontributing to death b	out not resul	ting in the ur	derlying cause giv	ven in Part	11.	23e. Did to	obacco	use contribute to	the cause of death	1?
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. I Director: After this certificate has been signed by ed in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	å	25. Was case referre	./	Hospital:					ath (Check				2 No	
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To the within To the comp		20h Signature and		120610			29c. License	number	11.6		29d. D	ate signed (Monti	n, Day, Year)	
		30. Name and addre	ess of person who c	completed cause of d	eath (Item 2	(3a) (Type, Pr	int)	0	117	140		1266		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lola Mae Walker 9:35 May p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Hospice Birthplace (State or Foreign Country) 17A If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Hours 1 M 2 KF 81 227-30-9249 Director VA Usual Residence of Decedent 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State death with the Maryland 10c. City, Town or Location Baltimore 10d. Inside City Limits Director n/a MD 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA 4106 Potter Street, Apt. 201 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 No filed within 72 hours after Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
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once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home Nurses Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Jackson Ernest Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ora White/Daughter 2601 Madison Avenue, Baltimore,MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State King MemorialPark 6-4-2010 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Fineral Hone P.A. of Baltinone County Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Adenocarcinoma disease or condition resulting in death) **Medical** Due to (or as a consequence of) . Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a g 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Myocardial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s his certificate hil director, page 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 A Other (Specify) 1 ☐ Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident Investigation 6 Could not be 3 Sulcide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 K Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) R149194 (RNP 28,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 51 Towson. 21204 N. Charles Grant

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Regi trar's Signature

10-04039 Jerome Wotorson

	Please Type or Print in Black Indelible Ink. Ensure All Copi	ies Are Legi	ble.		
	State of Maryland / Department of Health and Mental F	Hygiene	2010	1727	
te	Certificate of Death	Reg.		1 1 4 4 1	
ent's	Name (First, Middle,Last)	2. Date of Death		3. Time of Death	
ME	WOTORSON	Month E May 27 201	Day Year	0048 hrs	

		1- For State Registrar		Ce	rtificate of	Death			F	Reg. No.	20	1 0	1161	(_
Physici	an/	Decedent's Name (First, Midd	e (First, Middle,Last) 2. Date of Death 3. T									3. Time of Death		
edical Exami	ner	JEROME WOTORS	ON						Month May 27, 2	Day 2010	Year		0048 hrs	
		4a. Facility Name (if not institution	n, give street and n	umber)	4	b. City, Town, o	r Location				. County of	f Death		
		Montgomery General	Hospital			Olney				N	1ontgom	ery		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yes	ar If Und	ler 24Hrs.	8. Date of B	irth (MM/	DD/YYYY)		hplace (State or For	reigr
Director		218-29-2455	1 X M 2 F		78 _{Yrs} .	Months Day	ys Hour	rs Min.	9/26/	1978	3		untry)	
		Usual Residence of Decedent			113.								IBERIA	
any		10a. State 10b. County		10c. City	, Town or Locati	on							10d. Inside City Lin	nits
		MD MONTĠ	OMERY	OLN	ΕŸ								1 X Yes 2	
Maryland 28a-f show d at once.	ţ	40a Chant and Number				400 77 0 1								110
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 17541 LONGVIEW	T.N			10f. Zip Code 20832				LIBI	zen of Wha	at Coun	itry?	
ith the l 23a or notified		1,011 2011011211				20002								
h wit	Funeral	11. Marital Status 1 X Never Married 2 M	A a d C	cedent Ever in U		s Decedent of Hi es, specify Cuba				0-	14. Race - White,		can Indian, Black,	
or ite	Į.		1 Yes	2 X No		x	ii, Micziedi	i, i deite iti	(CO.)			BLA(CK	
215-0036 be flied within 72 hours after death with the Maryland natl Hygiene. red other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	by F	3 Widowed 4 Div	orced If Yes, Give Ye or Dates:	ar	1	Yes 2 No	specify	r:			Specify:			
lours natur	þ	15. Decedent's Education (Spe	cify only highest gra	ide completed)		's Usual Occupa ost of working life				16b. K	and of Bus	iness/Ir	ndustry	
6 72 h	lete	Elementary/Secondary (0-12)	College (1-4 or 5+)] doming me	-	ITER		-,	PR	CVATE			
O3	Completed	12												
5-0 led v	ပိ	17. Father's Name (First, Middle, JEROME P. WOTO	Last)				18.Mothe	r's Name (F	irst, Middle,	Maiden	Surname)			
21215-0036 unld be filed within 7 Mental Hygiene. marked other than	Be	official i. word	I(BOI)				EVAN	GLINE	J. ME	ETZGI	ER			
21 ould J Me S ma	ပု	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address (Stre	et and Nur	mber or Rur	al Route Nu	mber, Ci	ty or Town	, State,	Zip Code)	_
MD nd 2 sho alth and m 27 is aumatic		RONNIE WOTORSO	N/BROTHEF	}	4853 M	MARSHA I	DR.,	ATLAN'	TA, GA	4. 30	0126			
e, lead land Heal Heal item		20a. Method of Disposition			Place of Disposi		metery,	[Date	20c. t	ocation - (City or	Town, State	
Baltimore, MD 21215-0036 Departit. Pages 1 and 2 should be filed within 72 hours after Department of He lath 1 and Mental Hygiene. In friem 77 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		1 Burial 2 Cremation		rom State	crematory or oth TE OF HI		eM.	6/12	/10	STI	WEB	SPR	ING, MD	
Itin ii. P. rime ortan		4 Denation 5 Other Sp 21. In a ture of Funeral Service	ecify:	011		ame and Addres		N				DI 10		_
Ba Perm Depa Impo		A A A A A		1.100	22.14	anie and Addres	S OF Facilit	CAP	ITOL N	ORTU	JARY			
Dharinina	-	23a. Part I. Enter the disease, or	complications that	raused the death		25 MARYI							02 Approximate Inter	n (al
Physician /Medical		failure. List only one gause	on each line.				, 3001 43 0	Sardiac or re	espiratory ar	rest, silo	ck, or riear		Between Onset a	
Examiner	i	Immediate Cause (Final asease		rotic Cardiov		ease							Death	
•		or condition resulting in death)	Due to (or as	a consequence o	f):									
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to /or as	a consequence o	f)·									_
	Examiner	cause. Enter Underlying Cause	C.	a consequence o	1,1.									
_ =	xan	(Disease or injury that initiated events resulting in death) Last		a consequence o	f):									
executed an and al - trans			d											
760, icate be executed physician and the burial - transit	/Medical	UNPENDED	AMENDED											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	We W	IF FEMALE:		outcome of preg						23d	. Date of d	lelivery		_
687 ertification		23b. Was decedent pregnant in th past 12 months?	I Live			al death 3	Ectopi	c pregnanc	у		Month	D:	ay Year	
Box 68 e death certifier the attending ed for use as	Sici	1 Yes 2 No 9 Unk	2011	nant at time of de	oth 5 Oth	er (Specify)								
he de	Physicia		9011K11		101 - 1 - al				Loo- Div					
P.O. es that the igned by	by F	Part II. Other significant conditi	ons contributing t	o death but not r	esulting in the ur	iderlying cause (given in Pa	art I.					he cause of death?	
S, F			-						1 V Ye	s 2	No 3	Proba	ably 4 Unknow	л
requisition of the strength of	Completed								24a. Was auto				opsy findings availal empletion of cause of	
e lav	Ē						-		perfo	rmed?	de	eath?		"
Real The		25. Was case referred to medical				26 Place	of Dooth	(Check onl	1 Yes	2 No	1 1	✓ Yes	2 No	
Division of Vital Records, P.O. Box 68' and or Attending Physician: The law requires that the death certificate death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	a	examiner?	Hospital:	Inpatient 2	ER/Outpatient		Other	Nursing F		Resider		Other:		
Physic er this	의	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time of In		ry at Work		d. Describe	,		,		_
n of Nding Ph. h. After t	Certification:	1 Natural 5 Pend	(Month	n, Day,Year)			Yes 2		. Docorio	now mya	, 00001100	•		
Sio Atten deat cetor	g		tigation	of Lite At h						O: .				
Division pital or Attencours after death neral Director: filled in by the	#		not be	ce of Injury - At he	ome, tarm, street	, factory, office t	ouilding, et	ic. 28	or Town, S		nd Number	or Rura	al Route Number, Ci	ity
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	छ	4 Homicide	mined (Specify)											_
To the Hos within 24 h To the Fur completely	g	(Check only one) 2 Medical Exar	ysician: To the be											
To th To th	edical		and manner s	stated.				cuited at ti	ie time, date	,				
	Σ	29b. Signature and title of certifie	r			29c. Licens				29d. D	ate signed	I (Mon	th, Day, Year)	
		and				O.C.	M.E.			May	27, 201	0		
12.1		30. Name and address of person	who completed cau	se of death (Item	23a)									
2 V	İ	Ana Rubio MD. Ass	istant Medical	Examiner	111 Penn St	reet, Baltimo	ore, MD	21201						
	ate	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signatu	ire									
Regist	rar	JUN 0 3 2010	General	1.	Sound of									_
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10-04142

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ralph West		- For State	tate of	Maryla		artment of		nd Men	tal Hyg		Reg. No.	nli	n	17273
Physician Medical Examine	1/	Registrar 1. Decedent's Name (First, Mid		 Ralph	n E. Wes	st			1	Date of De Month May 31, 2	ath Day	Year	3.	Time of Death 0552 hrs
		4a. Facility Name (if not institut 2211 W. Rogers Ave			umber)		b. City, Town, o Baltimore	r Location o			4c. C	ounty of D	eath	
Funeral Director		5. Social Security Number 507-03-6720	6. Sex	2F	7. Age (In yrs. 92	last birthday) Yrs	If Under 1 Year		Adin	8. Date of B April		lF:	oreign	lace (State or ryNebraska
Maryland 28a-f show any 1 at once.		Usual Residence of Decedent 10a. State 10b. County MD N/				y, Town or Locat altimore								Od. Inside City Limits
the Maryli	=	10e. Street and Number 2211 W. Rogers	Aven	ue I	RM 108		10f. Zip Code 21	209			10g. Citize U.S		Country	17
5 ° 1 U	by Funeral		farried X	Armed F X Yes es, Give Yes pates:	2 No	1	s Decedent of Hi es, specify Cuba Yes 2 XXNo	n, Mexican, specify:	, Puerto Ri	can, etc.)	Sį	White, electify: Wh	tc. nite	
036 athin 72 hours and. rr than "natur	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12 12		ghest grad College (1 2			t's Usual Occupa ost of working life 'ISOT	e. DO NOT	use retired	(1)	Gen			ounting
21215-0036 Juld be filed within 7 Mental Hygiene in narked other than ic event, the Medica	8	17. Father's Name (First, Middle Beaty Elmer	West					Pear	rl Au	irst, Middle, Igusta	Mitc	hell		
MD 27 ad 2 should ulth and Ms an 27 is ma aumatic en		19a. Informant's Name/Relation Ruth B. West				2211	Address (Stre W. Roge	rs Av	enue	Balt	o, MD	212	209	
Baltimore, MD cernit. Pages I and 2 sh Department of Health and Informatic. If item 27 in injury or other traumat		20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other S	pecify:	Removal fr	nm State	Place of Dispos crematory or oth tlantic	er place) Cremato	ry	6/3/		Gle	n Bur	mie	
Balt permit Depart Impor injury		21. Signature of Funeral Service	00	ente		1363		Road	Bal	to.MD	212	11		
Physician Media Examiner	1	23a. Part . Enter the disease, of failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	on each line a. Hyp	^{ne.} p ertensi		lerotic Cardi			ardiac or re	espiratory ar	rest, shock	, or heart		Approximate Interval Between Onset and Death
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus. (Disease or injury that initiated events resulting in death) Last	c. Due		consequence									
execution and and and training and and training and and an anti-	<u>g</u> -	UNPENDED	dAN	MENDED										-
for att	: 왕	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Ur	he 1	Live b	ant at time of d	2 Fe	al death 3 ner (Specify)	Ectopic	pregnanc	у		Oate of deli onth	ivery Day	Year
P.O. es that the iigned by ti	6	Part II. Other significant cond	tions con	tributing to	o death but not	resulting in the u	nderlying cause	given in Par	rt I.					cause of death?
Vital Records, P.O. B ysician: The law requires that the discertificate has been signed by the director, page 2 should be detached	Completed									1 Yes	psy orm <u>ed</u> ?	prior deat	to com	sy findings available pletion of cause of
F Vital Physician: r this certiful director	e n	25. Was case referred to medic examiner? 1 Yes 2 No	Hospi	tal: 1 📗 I	Inpatient 2	ER/Outpatient		of Death (Other		y one) Home 5	Residenc	e 6 🗸 0	ther: So	cene
ion of tending Ph tending Ph death. tor: After the funeral			ding estigation	28a. Date (Month	of Injury , Day,Year)	28b. Time of li		ry at Work?	- 1	3d. Describe	how injury	occurred		
Division of Norther Hospital or Attending Phywithin 24 hours after death. To the Funeral Director. After the completely filled in by the funeral Confidence of Confidence	Certification:	4 Homicide det	ld not be ermined	(Specify)		nome, farm, stree				or Town,	State)			Route Number, City
the Ho vithin 24 h	<u>ه</u> ا	Tolloon only	aminer: On t		of examination a	dge, death occur and/or investigat								ause(s)
		29b. Signature and title of certif	er V	1	W	1-	29c. Licens O.C.					te signed 1, 2010	(Month,	Day, Year)
1		30. Name and address of perso Zabiullah Ali, M.D.			se of death (Iter cal Examine		n Street, Bal	timore, N	/ID 2120)1				
Stat Registra		31. Date filed (Worth, Day Year	0 6	32. Re	egistrar's Signat	ture								

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wolford Manth C Carl Michael Medical 4a. Facility Name (if not institution, give street and number) of Death Examiner Town, or Location 4c. County of Death Cgm. Social Security Numbe 6. Sex 1**X** M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ome Knasht Physician : Wolford, Michael Baltimore, Maryland 21215-0036 Months Days Hours Min. (Month, Day, Year) September 20, 1945 Maryland 212-42-7167 Director 64 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified in a piury or other traumatic event, the Medical Examiner must be notified. Baltimore N/AMaryland 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 21205 IISA 1051 Lerew Way 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Apple Ford 12 vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edna Garnetta Bonnell Carl Edward Wolford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2404 School Avenue, Dundalk, Md. 21222 **Brother** Charles E. Wolford Important: If iten any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of June Date 20c. Location - City or Town, State cemetery, crematory or other place)
Bayview Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service License ²² Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. thou 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ KESSINA 41/2 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner O MAP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed attending physician for use as the burial Physician/Medical CARCINIMA ON TONGUE 425 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the at be detached fo 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Did tobacco use contribute to the cause of death? Completed by me w/ NI REMINE 1 Yes 2 No 3 Probably 4 Unknown HEMANTS C 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 1 Yes 2 No X Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) this eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred □ Natural 5 Pending work' SUBDECT FELL 2 Accident 5/15/10 Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify), 28f. Location (Street and Number or Rural Route Number, determined Homez BAN MA 21245 cover wort; within 24 hours a Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 28/10 6-122 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOESCIA um CHARLOS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? HVS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 Physician/ Month May ^D2010 Regina Waldman 30 1:30 P ^M Medical 4a. Facility Name (if not institution, give street and number) 3 **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center <u>Parkville</u> <u>Baltimore</u> 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, May 19 **Funeral** 2010 9. Birthplace (State or Foreign 1 ☐ M 2 ☐**X**F ^{Year}1915 Hours Min. 216-48-2659 Maryland Director Yrs. Usual Residence of Decedent or 28a-f show notified at 10a. State Waldman May 30, with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo Maryland **Baltimore** Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? of Health and Mental Hygiene. fitem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 8830 Walther Blvd U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed 3 ¥ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within thealth and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Regima 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>William</u> Be11 Georgie Sigler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul B. Waldman 17102 Wesley Chapel Road Monkton, Maryland 21111 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other 1 20b. Place of Disposition (Name of Dulaney Valley Her place, Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) 6-4-2010 Timonium Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 pronths?
1 Yes 2 No Day Year signed by the a 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify, ျှ 1 X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide 5 \square Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year) 8 2010 who completed cause of death (Item 23a) (Type, Print) 30. Hame and 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Wilda M. Yurek 29 · 20p 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore l'owson ocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-14-6393 July 7, 1 M 2 52 F Months Days Hours 88 Yrs Director MD Usual Residence of Deceden 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director Baltimore Middle River 1 Yes AND No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12938 Community Drive 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural" 3X Widowed 4 Divorced Completed Il Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 10th own home Uth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Shine MArgaret Behr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau Dennis Yurek /son 8012 Yellowstone Road Kingsville MD21087 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Belair Memoerial 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 6/3/10 BelAir MD 4 Dopation 5 Other (Specify) neral Savice Lice 22. Name and Address of Facility 300 Mace Ave. Balto. MD Funeral Home of Essex 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and -transit Physician; The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death by the 1 ☐ Yes 2 ≠ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **To the Funeral Director:** After this certificate has been signed completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending 1 Natural 1 Yes 2 No Accident Suicide s after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 164395

DHMH 17 Rev 7/2009

Registrar

32 Registrar's Signature

DANIEUE OUBERMAN, MO 6701 NCHARLES ST, 8UITE 4105 BALTIMIRE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 0 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ E. Zollner Mayth 29 Day 201 Opar 2:30 AM Frank Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Arm Baltimore Glen Meadows Social Security Numbe Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** 214-01-3134 91 Months Hours OCt. 23, 1918 Maryland Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Baltimore Glen Arm MD 1 Yes 2 X No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21057 11630 Glen Arm Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married à 1 X Yes If Yes, Give 2 🗌 No Maryland 21215-0036 white 1 Yes 2 No Specify. Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7/2 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Glen L. Martin Company Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor 12 Be 17. Father's Name (First, Middle, Last)
Peter Zollner 18. Mother's Name (First, Middle, Maiden Surname) Magdalena Resch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3825 Bagville Road-Baltimore, Maryland 21220 Karen McCauley -daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of June 3,2010 20c. Location - City or Town, State emetery crematory or other place). Evans Funeral Chapel and Cremation Services Belair 1 Durial 2 X Cremation 3 D Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chapel and Cremation Service 8800 Harford Road-Parkville, Maryland 21234 -ondrse hmi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed this certificate 1 Yes 2 No director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Jursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier June 01, 2010 (Item 23a) (Type, Print MOCHOL of deat MO ZIZOY CX 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

1- State Registrar AMEND 29D PER DR. G907 9/24/Qertificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Pate of Plath 14, 2010 **Physician** Anderson -- Zoio 0355 Marie DLL___+2> Ava /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore City University of Maryland Medical Center R. Date of Birth (Agar) 2010 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗓 F none Maryland April-13--2010 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite MacCall Experiment 1 ¥ Yes 2 □ No Director Maryland Harford Belcamp 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1408 Dalmation Place #204 21017 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify. Specify: 2 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nóne never worked never worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Tuong Vinh Anderson Amber J. Carrick-Walter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1408 Dalmation Place #204, Belcamp, Maryland 21017 Amber J. Carrick-Walter (mother) Baltimore, 20c. Location - City or Town, State West Chester. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State R.A.Ferris & Co., Inc. 04/17/10 Pennsylvania 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Sign ture of Funeral Service Lice Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Extreme disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed certificate 1 ∐Yes 2 XXNo 1 ☐ Yes 2 🗷 No e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year)
: 4/14/10 29b. Signature and title of certifier 29c, License number MD 18912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DAVEY

KATRINA

PR 2 1 2010 June B. park

22 S GREENE ST BALTIMORE MZ

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Registra

2

29b. Signature and title of certifier

Zabiullah Ali, M.D. 31. Date filed (Month, Day Year

me and address of person who completed cause of death (Ite

Assistant Medical Examiner

32. Registrar's Signature

29c License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 20 To Sylvia Ianthe Agard 1:30 pM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 🗓 F Days Hours $A_{\mathbf{ugust}}^{(Month, Day, Year)} 1924$ Barbados 220-37-5319 Yrs. Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director 1 Yes 2 X No Montgomery Village Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20886 United States 19112 Capehart Drive within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give **Black** 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Board of Directors
Corporation Secretary 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Airlines Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) e 1 and 2 should be file of Health and Mental H fitem 27 is marked ot item 27 is marked other traumatic ev ည James Augustus Smith Una Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19112 Capehart Dr. Montgomery Village, MD 20886 June Allison Porter (Daughter) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot ☐ Burial 2 【 Cremation 3 ☐ Removal from State Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Aspiration Pneumonia Medical Due to (or as a consequence of Examiner Conjestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and s the burial-transit Acute Respiratory Failure or Attending Physician: The law requires that the death certificate be executed Exa Due to (or as a consequence of) resulting in death) Last Physician/Medical Coronary Artery Disease Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 ☐ Unknown signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? this certificate 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Certificate: injury 5 Pending X Natural 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number May 14, 2010 D41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctors Dr. Germatown, MD 20874

State Registrar Vinu Ganti M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 15, Physician/ 2010 6:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 916 Gabel Street Silver Spring Montgomery
9. Birthplace (State or Foreign Social Security Number 6. Sex . Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 K M 2 🗆 F Months Days Hours Min. Nov. 26. Year 19<u>17</u> Director 577-03-2836 Virginia Usual Residence of Decedent show ^{10a. State} Maryland 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director Montgomery Silver Spring 28a-f 1 Yes 2 X No 10e. Street and Number 10f, Zip Code ò 10g. Citizen of What Country? Funeral 23a 916 Gabel Street 20901 USA Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 5 þ 1 Never Married 2 Married 1 Yes 2X No Specify: If Yes, Give Year or Dates "natural", Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transportation should be filed with h and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Allen Sally Goodman 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 i Patricia A. Robertson 916 Gabel Street, Silver Spring, MD 20901 /Daughter injury or other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important: If ite Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State May 21, 2010 Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death 3 months Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Yes 2 No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Diabetes Mellitus 1 Yes 2 X No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death' 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 K No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funera 1 XNatural 5 Pending hours after death. 1 Yes 2 \square No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check To the Within 2 **Certifying Nurse Practionen T** who best of try knowledge, death occurred at the time, 29b. Signature and tite of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D03792 May 17, 2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

Irnest S. Oser, MD 10301 Georgia Avenue #304, Silver Spring, MD 20902

decress of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriah-transit completely filled in by the funeral director, page 2 should be detached for use as the buriah-transit Division or Vital Records, P.O. Box 68760,

dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequent b. Advanced Due to (or as a consequent c. Congestive Due to (or a deconsequent	Dementia ce of):				
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deati	ath 3 □Ectopic pregr			23d. Date of delivery Month Day	Year
Completed by Physician/Medical	Part II. Other significant conditions of Hyperfension Diabetes mell		g in the underlying caus	e given in Part I.		24b. Were autopsy fi prior to complet death?	4 □Unknorndings availat
Be (25. Was case referred to medical examiner?			26. Place of Death	(Check only one)		
ို	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER			me 5 Residence		
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	b. Time of 28c. Injury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred	
ertific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home building, etc. (Specify)	, farm, street, factory, of	fice	28f. Location (Street ar City or Town, State	nd Number or Rural Rou e)	te Number,
Medical Certification:	29a. Certifier 1 ☑ Certifying Ph (Check only 0ne) 2 ☐ Medical Exam	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	dge, death occurred at t and/or investigation, in	he time, date and place, my opinion, death occurr	and due to the cause(s red at the time, date an) and manner as stated d place, and due to the	cause(s)
Me	29b. Signature and title of certifier	0		cense number 69568	29d. Da	te signed (Month, Day,	Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

18 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. Chilakamarn, 6121 Montrose Road, Rockville, MD 20852

10-04057 David Bruce Ash	enf	Please Type or State o	· Print in Blac of Maryland / [gible	e. 2010	17283		
		1- For State Registrar		Certificat				R	leg. No.	2010	17200		
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) DAVID B . AS	SHENFELTE	R			d	2. Date of Dea Month May 27, 2	Day	Year	3. Time of Death 1630 hrs		
(4a. Facility Name (if not institution, give 271 New Bridge Road	street and number)			Town, or Lo g Sun	cation of Death			c. County of Deat Cecil	h		
Funeral Director		5. Social Security Number 6. Sex 187-46-7514 x	7. Age (I	n yrs. last birthd: 56	ay) If Und Month	er 1 Year ns Days	If Under 24Hrs. Hours Min.	8. Date of Bi		/DD/YYYY) 9. Bi 1954 Forei			
yan		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location						10d. Inside City Limits		
*	ō	MD Cecil		Rising	Sun						1 Yes 2 X No		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 271 New Bridge	e Rd.		10f. Zip	Code 1911				izen of What Cou	intry?		
th with tems 23	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev				nic Origin? (Spe Mexican, Puerto I		D-	14. Race - Amer White, etc.	ican Indian, Black,		
ifter dea		3 Widowed 4 X Divorced	1 Yes 2		1 Yes 2	No :	specify:			Specify: W	hite		
hours a	ted by	15. Decedent's Education (Specify only Elementary/Secondary (0-12)		dur			n (Give kind of w		16b.	Kind of Business	Industry		
036 ithin 72 inc. r than '	Completed	1 2	College (1-4 or 5+)		Clerk				E	Electri	c Company		
15-0 filed w al Hygie ed othe	Be Co	17. Father's Name (First, Middle, Last) Charles Ashen	felter	•		18	Mother's Name Mildre						
212 ould be d Ments s mark fic even	To B	19a. Informant's Name/Relationship (Ty	pe, Print)				and Number or R	ural Route Nu	mber, C	ity or Town, State			
, MD and 2 sh ealth an		Mildred Ashenfo	elter (mo	ther)				Holme		PA. 19			
nore ages a ant of Ha		1 Burial 2 Cremation 3	Removel from State	crematory	or other place)				ŕ	owne, PA.		
Saltir ermit. P bepartme mporta njury or		4 Donation 5 Other Specify: 21. Signature of Funeral Service License			22. Name and Galena	Address of Fun	Facility Teral H	ome o	f S	tephen	L Schaech		
Physician	_		cations that caused the		IIIO WE	25 L L	TOSS 5	L. Gd	теп	a. MD.	21635 Approximate Interval Between Onset and		
/Medical Examiner		Immediate Cause (Final disease a.A	P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ire. List only one cause on each line.										
		, , , , , , , , , , , , , , , , , , ,											
	Examiner	if any, leading to immediate D cause. Enter Underlying Cause	e. Enter Underlying Cause ase or injury that initiated C										
executed ian and ial - transit		events resulting in death) Last d.	ue to (or as a consequ	ence of):									
O, be exect sician a	edical	UNPENDED	AMENDED				-						
Sox 68760, leath certificate be e e attending physicia for use as the buria	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live birth	2	Fetal death	3	Ectopic pregnar	псу	23	Month	y Day Year		
Box (e death ce the attence the attence the attence the dor use	Physician/Med	1 Yes 2 No 9 Unknown	4 Pregnant at tim 9 Unknown	e of death 5	Other (Spe	ecify)							
ires that the d		Part II. Other significant conditions	contributing to death bu	ut not resulting in	n the underlyin	g cause give	en in Pert I.		_		the cause of death?		
ds, P. equires the equires the ould be d	eted	Cirrhosis of the Liver					_	24a. Was	an	24b. Were a	utopsy findings available		
of Vital Records, ing Physician: The law required After this certificate has been someral director, page 2 should be	Completed by							auto perfo	rmed?	prior to death?	completion of cause of		
tal R cian: T certific ector, p	Be C	25. Was case referred to medical examiner?	spital: 1 Innationt			0	f Death (Check o						
of Vi g Physi fter this	٩	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Tin		28c. Injury		g Home 5 28d. Describe		ence 6 🗸 Othe	er: Scene		
tending death. tor: Al	ation	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,Year)			1 Ye	s 2 No						
Division of Pipilal or Attending Phours after death.	Certification:	3 Suicide 6 Could not be determined	28e Place of Injury	/ - At home, farm	n, street, factor	y, office buil	lding, etc.	28f. Location or Town,		and Number or R	ural Route Number, City		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buil	Medical C	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the best of my kr On the basis of examin and manner stated.										
F 3 E 8	Me	29b. Signature and title of certifier			29	c. License				Date signed (Mo	onth, Day, Year)		
		30. Name and dudess of person who co	mpleted case of deat	th (Item 23a)		O.C.M	.C.		IVIa	y 28, 2010			
		Russell Alexander MD. A	ssistant Medical	Examiner	111 Penn	Street, B	Baltimore, MI	21201					
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	arked				OCM	1E			
ma _k			E.	177									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Рм 5:51 John Jefferson Burch II 05/17/2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Garrett County Memorial Hospital 0akland Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 67 217-40-5435 Maryland Director 04/09/1943 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Garrett McHenry 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 2095 Rock Lodge Road 21541 items 23a United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Marical Examinations. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. ğ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications 12 Electronic Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luverna J. Hoyle ပ William Jefferson Burch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Burch, Wife 2095 Rock Lodge Rd. McHenry, MD 21541 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Valley Cemetery 05/20/2010 Oakland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home P.A. 21. Signature of Funeral Service Licensee 21 N. Second Street Oakland, MD 21550 Kathuru Sucher 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyfig, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WEVERSON Immediate Cause (Final disease or condition resulting in death) -Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 □No 1 ☐ Yes 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 2 ☐ ER/Outpatient 3 🔭OA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Excertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3.17.10 D23979

Registrar DHMH 17 Rev 1/2001

State

311 N. Fourth Street, Oakland, MD 21550

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Registra s Signature

Robert A. Goralski

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:55 A^M 05/22/2010 /Medical Paul Junior Bennear 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 110 Decatur Street 0akland Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 ☑ M 2 ☐ F 59 Director 235-80-3449 11/11/1950 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be political at 1 X Yes 2 ☐ No Director Elk Garden WV Mineral 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code P.O. Box 95 26717 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene, Elementary/Secondary (0-12) College (1-4or 5+) Coal Coal Miner and Mental Hygin is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Paul Bennear <u>Dolly Dawson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Starla Bennear, Wife P.O. Box 95, Elk Garden, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalbaugh Cemetery 05/25/2010 Elk Garden, WV 22. Name and Address of Facility David A. Burdock Funeral Home P.A 21. Signature of Funeral Service Licensee Katherine Sweins 21 N. Second Street Oakland, MD 21550 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYUCARDIAL /Medical Examiner URONARY Sequentiany flet our differs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit YPERLIPIDEMI Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1∐Yes 2∐No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖰 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

HIIan 31. Date filed (Month, Day,

#/V# 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WU 19761

77 MISTORIO WU 26739

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BRIDGES 7:50A SHIRLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL FREDERICK FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Feb. 13,1943 Johnstown, PA Director 200-32-9561 67 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must han material. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Frederick Frederick 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21703 U.S.A. 6829 Buttonwood Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 WHite 1 ☐ Yes 2 ☐ No Specify: Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary (Spconday (0-12) College (1-4 or 5+) Law Offices Receptionist Be 18. Mother's Name (First, Middle, Maiden Surname) Helen Medvic 17. Father's Name (First, Middle, Last) ည Stephen Sroka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6829 Buttonwood Court Frederick, Md. 21703 Thomas Bridges/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5-18-2010 Southmont, PA. Grandview Cemetery ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Market St. N Frederick, Md. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 4 Pregnant g Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performe After this certificate has 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 2 🔀 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопретер 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Exertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) -2010 person who completed cause of death (Item 23a) (Type, Print) 30. Name and addres 12 trederick, M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Hilda Dolores Brooke May 14, 2010 2:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Gaithersburg 21904 Goshen School Road Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Year) Months Days Hours Min 1 □ M 2 🛛 F Director 579-01-2406 98 8, 1912 Washington, D.C Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10b County er than "natural", or items 23a or 28a-f show the Mudical Examinat must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Gaitherburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or any or other traumatic event, Its Muchal Experience must be a 21904 Goshen School Road 20882 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2
If Yes, Give
Year or Dates: 2 No 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify 2 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Prince Georges County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Allen Pixton ပ Mary Bessie Reidy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20882 21904 Goshen School Road, Gaithersburg, Maryland Harriet Frame, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 5/18/2010 Brentwood, Maryland ↓ □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityMolesworth-Williams Funeral Home 21. Signature of Fundam Service Licensee 26401 Ridge Road, Damascus, Maryland 20872 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediat Cause Final **Physician** Ateriosclerotic Cardiovascular Disease disease or resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the burial IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 □Yes 2 X No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Atrial Fibrillation 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 □Yes 2 🕅 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 💢 Residence 6 Other (Specify) 1∐Yes 2∭XNo 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Patter death.

Director: After t 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier medical doctor D20425 May 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Michael Α. Greene, 19640 Club House Road, Suite 410, Montgomery Village, MD 20886 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ $20\overset{\text{Year}}{10}$ Ruth M. Bouchelle 9:00p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Cecil Rising Sun 106 Mount St. Apt. 6 If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days April 25. 1 M 2 TXF Months Hours Country) 213-18-3002 MD Director 87 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 X Yes 2 □ No Cecil Rising Sun 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21911 USA 106 Mount St. Apt. death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Completed by Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🕅 No Specify Specify: and Mental Hygiene. 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany lnjury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Llewelyn Rawlings Elinor Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Boxwood Ln. Colora, MD 21917 Elaine Holbrook/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/2072010 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.T. Foard Funeral Home, P.A. Rising Sun, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
R. T. S. Queen St. Rising Sun, MD 21911 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Recta Pnysician Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 29d. Dat**e** sign**ed** (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Columa

of death (Item 23a) (Type, Print)

101

MD

32. Registrar's Sign

hvesher

D0033925

2010

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1 - State Registra Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 11:30 AM Margaret Elizabeth Blake May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 602 West Old Philadelphia Road North East Cecil Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 5, 1 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Hours Min. Director 213-24-5061 Pennsylvania Usual Residence of Decedent fshov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 X No Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 602 West Old Philadelphia Road 21901 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2**XX**No If Yes, Give Mary/and 21215-0036 1 ☐ Yes 2XXNo Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Clothing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert L. Meese Mary B. Albright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 West Old Philadelphia Road <u>Linda Gandy / Daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of May 19. XBurial 2 Cremation_3 Removal from State ModfitterVernour Thiled 4 Donation 5 Dother (Specify) Methodist Cemetery Whiteford, Maryland 21. Signature of mena Service Lie 22. Name and Address of Facility Crouch Funeral Home South Main Street, North East, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last -burialphysician the burial Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown the P.O. I cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ ک Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 V No death? Hospital or Attending Physician: The certificate 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioners to the best of my knowledge, death per nirred at the time, date and place, and due to the rause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 30 Name and address of Rerson who completed cause of death (Item 23a) (Type, Print MD2 monson 31. Date filed (Month, Day, Year) State Registrar

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			For State Registrar		State	e of Ma	aryland /			ent of late of L		and M	lental Hy	/gien Reg. N		U	1/290
ı	Physicia Medi		1. Decedent's Name Anna Lee										2. Date of D Month May 1	D	ay 010 Ye	ar	3. Time of Death 5:41 A M
	Examir		4a. Facility Name (if 8018 Wards) 5. Social Security No.	field I	_		e (In yrs. last bii	dhday)	Ga		sburg		8. Date of B			tgo	mery lace (State or Foreign
	Funeral Director		467-38-51 Usual Residence of	152	1 M 2 🗵	93		Yrs.	Month		Hours		Month, D	av, Year) 2, 1	916	Count Tex	ace (State or Foreign ry) as
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lary	should and M is ma		19a. Informant's Na	me/Relationsl	nip (Type, Print)		19	b. Mailin	g Addre						r Town, State,	Zip C	ode)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Patricia 20a. Method of Disp 1 Burial 2	osition Cremation	3X Removal f	rom State	20b. Place o	of Dispos	sition (\) natory o	ame of other plac	:e)	D	ate	20c. L	ocation - City	or Tov	
altin	permit. Pa Departme Importan any injury	4 Donation 5 Nother (SpecifEntombment Memorial Park Cem. May 17, 2010 Amarill 21. Signature of Funeral Service Ligensee M01597 22. Name and Addres amazansky-Goldberg Memorial Park Cem. May 17, 2010 Amarill 21. Signature of Funeral Service Ligensee M01597 22. Name and Addres amazansky-Goldberg Memorial Park Cem. May 17, 2010 Amarill 21. Signature of Funeral Service Ligensee M01597 22. Name and Addres amazansky-Goldberg Memorial Park Cem. May 17, 2010 Amarill 21. Signature of Funeral Service Ligensee M01597 22. Name and Addres amazansky-Goldberg Memorial Park Cem. May 17, 2010 Amarill 21. Signature of Funeral Service Ligensee M01597 22. Name and Addres amazansky-Goldberg Memorial Park Cem. May 17, 2010 Amarill											Memoria	al (Chapels Inc		
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. Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physicial director, page 2 should be detached for use as the bu	Physician/Medical Examiner	IF FEMALE; 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☑ 9 ☐ Unknown	pregnant nonths?	1	ive Birth 2	of pregnancy			c pregnanc (specify)	у				23d. Date of Month		ry Day Yea r
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Division of Vital Records,	or Attendir fter death. irector: Af n by the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig	ation not be 28e. Pl		y - At home, fa		M et, facto	1 🗆	Yes 2 N		8f. Location (Rural F	Route Number,
Ö	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completed filled in by the funera	Medical C	(Check 2	Medical E	xaminer: On the	basis of ex	pest of my knowledge, death occured at the time, date and place, and due to the cause(s) and mann sis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and du							e, and due to the	ne caus	se(s) and manner stated.	
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			Ira L.	Berger	, M.D.	1201	Seven I	Lock	s Ro	oad; l	Rockvi	lle,	MD 2	20854	1		
	Stat Registra	ie ar	31. Date filed (Month	18 20	0	2. Registrar	's Signature	and.	1								

Amend 23a, per PHYS, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 5/25/10, CCHD, drw State of Maryland / Department of Health and Mental Hygiene U | U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 2010 17 1:00 Рм George Aldon Barnard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Callaway St. Mary's St. Mary's Hospice House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 13, 1 9. Birthplace (State or Foreign **Funeral** Davs 1 ☑ M 2 □ F Months Hours Min Country) Washington, **Director** 220-32-5410 June Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Examiner must be notified at Director 28a-f 1 ☐ Yes 2 🖾 No Lexington Park Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a United States 20653 20548 Spring Hill Road . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or 9 1 Never Married 2 A Married Maryland 21215-0036 1 ☐ Yes 2 M No Specify: If Yes, Give Specify: White Completed 3 Divorced 4 Divorced Year or Dates and Mental Hygiene.

is marked other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Operating Engineer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ Alice Ruby Babb Donald Warren Barnard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25866 Ricky Drive, Hollywood, MD 20636 Kristina Bell / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/18/2010 Alexandria, Virginia Metropolitan Crematory 21. Signature of Funeral Service Licen 22. Name and Address of Facility Rausch Funeral Home, P.A. Lusby, MD 20657 P.O. Box 600, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Lower extremity gangrene Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami SRD Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury ON that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospice House Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 😡 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ျ this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? ___1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 🗆 Pending nours after death.
neral Director: Affilled in by the fur ☐ Accident ☐ Suicide Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

DHMH 17 Rev 7/2009

24435 Mervell Dean Road, Hollywood, Maryland 20636

May 18, 2010

Meratee

Maryam Meratee, M.D.,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 105 2010 Leah May Bowlus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington

9. Birthplace (State or Foreign Country) Washington County Hospital
5. Social Security Number 6. Sex 7. Age (III Hagerstown If Und 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗷 F Months Days Hours Min. Director 186-28-3953 21. 1932 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show e filed within 72 hours after death with the Maryla al Hygiene or Other then. other than "natural", or items 23a or 28a-f show vent, Ite Maries Expriment mast be rodiked as 1 ■Yes 2 No Directo Maryland | Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21713 U.S.A. Funeral 15 Potomac Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Manufacturing Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important if Health and Mental any Injury or other Annalee Martin <u>David K. Ebersole</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Potomac St. Boonsboro, Maryland 21713 Robert E. Bowlus, II 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/25/2010 Boonsboro Cemetery Boonsboro, Maryland 21. Signature Funeral Service Ligensee 22. Name and Address of Facility Bast-Stauffer Funeral Home 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final In eumonia **Physician** disease or condition resulting in death) /Medical Due to (o as a consequence of): Examiner Squerrous Cell Conce Ota Static Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ņē Due to (or as a consequence of). death certificate be executed physician and tha burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical attanding pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ξ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Proystuters, within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s autopsy 2 □No 2 1 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Dav. Year) 29b. Signature and title of eartifier 29c. License number 20311 Lappani Rd Bearbers MD 21313 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) 2 4 32. Registrar's Signature

Malik

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar	Sta	ate		-		et, Baitimore,	MD 21201								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2010 Month **Physician** Thelma Frances BENNER 14, 6:59 a. M May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Maugansville Washington 13831 Countryside Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept.19,1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min Virginia 1 ☐ M 2 🔀 F 90 Yrs. 217-22-4482 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f short the Medical Examiner must be notified at 1 ☐Yes 2 No Directo <u>Maugansville</u> Maryland Washington the 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 13831 Countryside Drive 21767 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify white Specify: ò 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) State Police file clerk other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be Noah Samuel Riggin ပ Christy Mae Ross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) it of Health Katherine M. Benner - Daughter 8888 Sawmill Road, Westover, Md. 21871 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Baltimore, Maryland Loudon Park Cemetery: 5/18/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** leukenna /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed ng physician and as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a d be detached for 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably icate has been si , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an autopsy perform 2 No 1 □Yes the Hospital or Attending Physiclan: in 24 hours after death.

The Funeral Director: After this certifica inpletely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) relative's 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural Injury 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aff 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1130

5/14/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/)831 M 2010 Harold Lee Boyer Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Washington County Hagers town If Under 1 Year If Under 24 Hrs.

Pays Hours Min. 8. Date of Birth May 2, 1936 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Marvland 217-32-5990 74 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director Smithsburg Maryland Washington county 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral items 23a 21783 687 South Main St. U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married 9 \$ Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes Give "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Professor College other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other ပ Luther Pearre Bover Anna Margaret Smith Boyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 687 South Main St. Smithsburg, MD 21783 Billie Sue Boyer-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Smithsburg Crematory 5-17-2010 | Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Congestive he Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner and -transit restonant Conduct Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events (or as a consequence of) resulting in death) Last physician a sthe burial-1 3705 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 □ No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown s been signated by 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? Yes 2 page death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Afte completed filled in by the fun 1 X Natural 5 Pending 1 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D14800 -du 5/14,2010 mussouls 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick St. Hagerstown. MD21740-MASSOUD B. ALIZADEH, HD 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY Registrar

10-03709 Omar Burkholder Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nar Burkhold	er		ate of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010 1729									
Physic edical Exam		1. Decedent's Name (First, Middle,Last) Omar Ray: Burkholder		2. Date of Deat Month May 14, 20	th Day Year	3. Time of Death 1357 hrs						
		4a. Facility Name (if not institution, give street and number) 4b. City, To 16851 SherpardsTown Pike Sharps	wn, or Location of D burg	Death	4c. County of Death Washington							
Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$		Main	th (MM/DD/YYYY) 9. Bird Cor	hplace (State or Foreign untry) laryland						
, w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits						
and show a	5	Maryland Washington County Sharpsburg				1 X Yes 2 No						
e Maryl or 28a-1	irect	10e. Street and Number 10f. Zip C 10f. East High St. 217	ode 782	10	0g. Citizen of What Cour	itry?						
with th ms 23a be noti	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent		? (Specify Yes or No-		can Indian, Black,						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Injuryoriant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other reaumatic event, the Medicial Examiner must be notified at once.	by Fune	1 Yes 2 No 3 Widowed 4 Divorced of Yes, Give Year or Dates:	X No specify:		Specify: Whi	ite						
72 hours n "natural Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4 or 5+)			16b. Kind of Business/l	ndustry						
-0036 I within giene. ther tha	dmo	10 Baker 17. Father's Name (First, Middle, Last)	18.Mother's N	lame (First, Middle, N	Bakery Maiden Surname)							
1215. I be filed ental Hy arked of	Bec	Nathan E. Burkholder	Ruth A	Arlene Mai	rtin Burkho							
AD 2' 2 should 1 and Ma 27 is mi	ြို	19a. Informant's Name/Relationship (Type, Print) Nathan Burkholder-father 19b. Mailing Address P.O. Box 26			nber, City or Town, State 21782	Zip Code)						
ore, N s 1 and of Healtl If item		20a. Method of Disposition 1	of cemetery,	Date	20c. Location - City or							
ltimo it. Page rtment ortant:	Hagerstown Fiery Fune	and the second s										
Ba perm Depa Impo		1) un los At June 1331 Ea	Hagerstown,	MD 21742								
Physician /Medical		23a. Part I. Enter the disease, or complications that couse, the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	dying, such as cardi	iac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death						
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause										
ted 1 unsit	Examine	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):										
6 be executed ysician and burial - transit	edical	UNPENDED AMENDED										
Ox 68760, eath certificate be executed attending physician and for use as the burial - transit	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pre	egnancy	23d. Date of delivery Month D	ay Year						
Box 6876 e death certificate the attending phy ted for use as the l	Physicia	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify	y)									
ires that the dissigned by the	₹	Part II. Other significant conditions contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributions.	ause given in Part I.		bacco use contribute to the 2 No 3 Prob							
tal Records, cian: The law require certificate has been si ector, page 2 should b	Completed			24a. Was a autop:	sy prior to c	opsy findings available ompletion of cause of						
Vital Recysician: The label bis certificate director, page		25. Was case referred to medical 26	.Place of Death (Ch	1 ✓ Yes		s 2 No						
'Vita Physicia r this ce	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DO			Residence 6 Other	Scene						
Division of Vital rate or Attending Physician: rate death. al Director: After this certiced in by the funeral director	27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Pending Investigation 28a. Date of Injury 28b. Time of Injury 1336 hrs 1 Yes 2 No Subject struck by train 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No											
Divisital or Attura after dura after dura I Directural Directura by Burectura by Burectura by	Certification:	3 Suicide 6 Could not be determined (Specify) Other (railroad tracks)	iffice building, etc.	or Town, St	Street and Number or Ruitate) dstown Pike, Sharpst							
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The haw requires that the death certificate within 24 hours after death. After this certificate thas been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical C	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the tile (Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my of and manner stated.										
JII "	Me	29b. Signature and title of certifier 29c. I	License number O.C.M.E.		29d. Date signed (Mor	nth, Day,Year)						
3		30. Wime and address of person who completed cause of death (Item 23a)			ay 10, 2010							
-	tate	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, E 31. Date filed (Marth, Day, Year) 32. Registrar's Signature	3altimore, MD 2	21201								
Regis		31. Date filed (Maria Day, Year) 2010 32. Registrar's Signature										

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 355 🕅 2010 Marqueritte Priscilla Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Maryland 1 □ M 2XXF March 19,1937 Director 73 214-36-0418 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 311 Belview Ave. 21742 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: "natural", 3 Widowed 4 X Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Supply Office Engineer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Margaret Priscilla Otzelberger Crampton Jennings Br<u>yan</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a: If item 27 is 16718 Virginia Ave. Williamsport, MD Scott B. Boyer - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation Removal from State 4 Donation Hagerstown Crematory | May 22,2010 | Hagerstown, Maryland 5 Othe 21. Signature of Juneral S Osborne Adrenerally Home, P.A. 425 S. Conococheague St. Williamsport, 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cholensio carcin Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transit that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician at the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed this certificate 1 Yes 2 No 2 - No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. Sompleted filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 Medical

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Benson Emma Mary Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Allegany Cumberland WMHS-RMC If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Country) PA 7. Age (In yrs. last birthday) Social Security Number Funeral Months Növ29 1 M 2 DF 77 217-28-9981 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Cumberland 1 XYes 2 No Allegany MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21502 Funeral 623 White Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by white Baltimore, Maryland 21215-0036 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) lay (0-12) **12** College (1-4 or 5+) Elementary/Seconday own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Elizabeth (Ludy) DeLozier Walter DeLozier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 623 White Avenue Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) son William Benson 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Sunset Memorial Park MD 5/29/2010 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name an Scarpe of Pulleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. P 11 Enter the usuale, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 0000 Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner or Attending Physician. The law requires that the death certificate be executed Cause (Disease or liniury attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ Day Year Month ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 🗌 No 1 🗌 Yes 2 A Yes within 24 hours after death.

To the Funeral Director: After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 100 မ 1 Yes 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at completed filled in by the funeral 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined 1 Certifying Physician: To the best of ply knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUMPER SETON DRIVE IKRAMADITYA POONALMD 924 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Cera 2010 May 11:33 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Adamstown Buckingham's
5. Social Security Number 6. Choice If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Sex 1 M 2 □ F Days (Month, Day, ine 23 Hours Min. Months 276-03-1428 Yrs 100 1909 **Director** Ohio June Usual Residence of Decedent show 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at 1 ☐ Yes 2 🛣 No 28a-f Frederick Maryland Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3200 Baker Circle 21710 United States items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White Specify: "natural", 1946 Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) +4 Colone1 US Army Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ should be t Louis Cera Anna Scarnechia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is Nancy Rooney / Daughter 0837 Easterday Rd. Mversville, MD 21773 other Lepartment of He Important: If item any injura 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5/17/2010 Loraine, Ohio Calvary Cemetery 4 Donation 5 Other (Specify) Stauffer Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that danked shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final CAD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No page 2 s has death? 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify, 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 2 No 1 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one the

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and Atle of

Parkview

31. Date filed (Month, Day, Year)

Ventrie

M

3000 - D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DO058726

Myersville

29d. Date signed (Month, Day, Year)

5-14-10

21773

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 2010 Sheldon Cohen May 1:40 р Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min New 1 🕱 M 2 🗆 F (Month, Day, Year) 10/03/1928 York **Director** 81 053-24-1262 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No <u>Maryland</u> Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 8407 Victory Lane USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 😾 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. 3 Divorced Completed WWII Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Jewe1ry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paul Cohen Sylvia Rollof 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Clarice Cohen, wife 8407 Victory Lane, Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gdns 05/12/2010 Olney, Maryland 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION,
1091 Rockville Pike, Rockville, 21. Signature of Juneral Service Licensee MO1255 20852 Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Sepsis Medical resulting in death) Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exam Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 No as been signed by the 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? this certificate 1 🗌 Yes 2 🗎 No 1 ☐ Yes 2 🗶 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending Accident 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

8

Joseph, Bindu C. MD, 1160 Varnum St, #21, Washington, DC

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D006034

May 11, 2010

20017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 15, Year Physician/ 2010 10:55 PM Dorothy Elizabeth Allen Carey Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Brookeville 3020 Holiday Drive Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗆 F Months Hours Min. Jun. 9, 1922 Mary Tand 87 Director 579-20-7731 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits I and 2 should be filed within 72 hours after death with the Maryland Fleatht and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State Director Brookeville Maryland Montgomery 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20833 USA Funeral 3020 Holiday Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary E. Bowen Claude E. Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10724 Brewer House Road, N. Bethesda, MD 20852 Robert J. Noyes / Executor 20c. Location - City or Town, State Washington, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 s
Department of h
Important: If ite
any injury or ot 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State District of Columbia May 19,2010 G1enwood Cemetery 4 Donation 5 Other (Specify) 21. Sign were f Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in recipied cause. Enter Underlying Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 🔀 No Year Month Day Pregnant at time of death ed by the a 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? 1 ☐ Yes 2 🔀 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ၉ 1 Yes 2 K No 1 Inpatient 2 ER/Outpatient 3 DCA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 XNatural M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number D35635 May 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 18111 Prince Philip Drive, Olney, MD 20832

State Registrar Joseph Kaplan,
31. Date filed (Month, Day, Year)

Registrar's Signatu

10-03738 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Douglas Wayne Callahan State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Wayne Douglas Callahan May 15, 2010 0936 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's **Bowie Health Center** Bowie 5. Social Security Number UPH 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** unk Foreign Months Days Hours Director 219-72-3389 1 X M 2 F 52 Yrs <u>5-1</u>6-1957 Nº. Carolina Usual Residence of Decedent 10a. State Un 10b. County 10c. City, Town or Location unk 10d. Inside City Limits 1 Yes 2 X No Maryland Prince George's 28a-f show Upper Marlboro timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
Trant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other transmatic event, the Medical Examiner must be notified at once. 10e. Street and Number - Unit 10f. Zip Code UTIK 10g. Citizen of What Country? 1171C 3903 Largo Rd. ö 20772 United States 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 X Yes If Yes, Give Year or Dates: 4 Divorced 1 Yes 2 No specify: White ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Welder Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Callahan Geraldine Nall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Callahan/Wife 3903 Largo Rd. Upper Marlboro, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Mdema Vereral Home Cheltenham, Md. 1 X Burial 2 Cremation 3 Removal from State 7-9-10 Funeral Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Lee Funeral Home Calvert, Coff Gary 8125 Southern Maryland Blvd. Owings, Approximate Interval 23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Immediate Cause (Final disease Multiple injuries Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical AMENDED 5-20c per fh g905 7-14-10 vt 23a,27,28a-f, per ME g904 6/7/10 TT After this certificate has been signed by the attending physician : funeral director, page 2 should be detached for use as the burial -X UNPENDED Records, P.O. Box 68760, The law requires that the death certif cate be IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed^{*} Yes 2 No 1 🗸 Yes funeral director, 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Inpatient 2 Z ER/Outpatient 3 Nursing Home 5 Residence 6 Other: 1 🗸 Yes 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred driver in auto auto collision To the Hospital or Auteuration within 24 hours after death.

To the Funeral Director: A 1 Natural Division 1 Yes 2 X No 5/15/2010 8:42 am 2 X Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) NB Rt 301 d 91d 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be or Town, State) NB Rt 301 @ old Central Ave Mitchellville, MD determined (Specify) roadway 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifier

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 16, 2010

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	with t	Funeral Director	709 James Court				32547		1	-	ted		
	death item:		11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an. Mexican. Puert	pecify Yes or No-			e - Americ	can Indian,
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Maryland 21215-0036		일 B	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne <i>(First, Middle,</i> .a Manza			r)	
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Baltimore,	of Heal of Heal of Item 2		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐		20b. Place o	f Dispo	sition (Name of natory or other place	ce)	Date	20c. L	ocation -	City or To	own, State
Ë	Pagi tment tant: jury c		4 ☐ Donation 5 ☐ Other (Specif	fy)	Metro								Virginia
Bai	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licenter	7 Delle	1	10 G	Name and Address East Deat Lithersbu	ss of Facility De er Park irg, MD 2	Vol Fun Drive 0877	eral	. Hom	e	
			22 . Part 1. Enter the disease, or com shock, or heart failure. List only o	plications that cause ne cause on each lin	d the death. Do re.	not ente	r the mode of dyin	g, such as cardiac	or respiratory as	rrest,			Approximate Interval Between
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	physic the b			d									
89	eath certificate be attending phys	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy		Ectopic pregnanc				23d. Dat	e of delive	ery
Box	death ne atte ed for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 🖾 No	4 Pregnant a			Other (specify)				Moi	nth	Day Year
P.O.	at the d by th etach		9 ☐ Unknown Part II. Other significant conditions or		out not resulting	n the u	nderlying cause giv	ven in Part I.	23e Did t	nbacco	use contr	ibute to th	he cause of death?
<u>s</u> , п	Attending Physician: The law requires that the death certificate death. ector. Addth. ector. Atter this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	ed by							1 🗆	Yes 2	□ No	3 🗆 Prol	babiy 4 🖾 Unknown
Division of Vital Records,	w require ts been s 2 should	Completed							24a, Was		24b. V	Vere auto	psy findings available impletion of cause of
Bec	The law ate has page 2:	Com							_ perfe	ormed?	C	leath?	
ta	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Pl	ace of Death (Che	ck only one)				
Σ	Physic rthis ral dir	2	1 🔀 Yes 2 ☐ No 27. Manner of Death	1 Inpati	ient 2 🔀 ER/Ou	itpatien Time of	t 3 DOA 28c. Injun	4 U Nursing H	lome 5 Resi				2
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/isic	r Atte ter dea rector	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju		rm, stre	et, factory, office		28f. Location (er or Rural	Route Number,
ă	Hospital or 24 hours afte Funeral Dir sted filled in		O O US A STORY OF THE										
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completed filled in by the funeral	Medical	(Check 2 Medical Exami	sician: To the best of iner: On the basis of e se Practioner: To the	examination and/o	r investi	gation, in my opinio	on, death occurred	at the time, date	and place	e, and due	to the car	use(s) and manner stated.
	To the I	-	29b. Signature and title of certifier		- 40 T		29c. License	number		29d. Da	ate signed	(Month, I	Day, Year)
	10		Daniel K.	theh,	JIM)		D 673	355		May	7 16,	201	0
			30. Name and address of person who c					Dond C41	war Car	ino	MD	2090	2
	Stat	te.	Daniel Kenneth She	32/Registra	ar's Signature		st Glen F	wau, bil	ver shr	rug,	FID	2070	
	Registra	ar	31. Date filed (Month, Day, Year)	10 Delma	- A	par	Kil						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 6:20 P^M URIE MAY 15 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Boonsboro Reeders Memorial Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 1 F Yrs. April 22 1939 Maryland 214-36-0897 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 □ No Washington Boonsboro Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 141 S. Main Street 21713 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐Yes 2X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School System Data Processing 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Katherine Matthews Robert Edward Dudley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1028 Brinker Drive #101, Hagerstown, Md. 21740 <u>Peggy Dudley - Sister-in-Law</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 5/18/10 Hagerstown, Maryland 21. Signature of Funeral Service Gens 22. Name and Address of Facility Minnich Funeral Home anch 415 E. Wilson Blvd. Hagerstown, Md. 21740 Part 1. Inter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE MASSIUE IHR. Due to (or as a consequence of): DEMENTA YEMRS Mounced Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 WUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

Show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any lighty or other traumatic event, the Modical Experiment and be notified at once.

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

of Vital Records,

Division

the Maryland

/Medical

Director

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physician and s the burial-transit law requires that the death certificate be executed attending nse ō detached 1 the signed by t page 2 should peen certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Examine Physician/Medical þ Completed Be Certification: To

IF FEMALE: □Yes 2□No 9 Unknown

23b. Was decedent pregnant in the past 12 months?

examiner? 1 Yes 2 No

2 Accident 6 □ Could not be 3 Suicide determined 4 Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifie pdu

29d. Date signed (Month, Day, Year)

DR. GHAZALA QADIR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-432-8470 20311 Lappans Road, Boonsboro, MD 21713

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 19



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 19, Venetia Rose CLOPPER 2010 2:10 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport Nursing Home Washington Williamsport Social Security Number If Under 1 Year 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 □ M 2 🖾 F May 18, 1921 89 214-14-6119 Maryland **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am prigraphy or other traumatic event, the <u>Medical Examiner must be</u> notified at once. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 🗌 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 18507 Orchard Hill Parkway 21742 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) clothing factory seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph R. Cunningham Nenna Louise Fair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Kane, Esq. - attorney 29 W. Franklin St., Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 5/21/10 Hagerstown, Maryland 4 Donation 5 Other (Specify) MINNICH FUNERAL HOME 21. Signature of Funeral Service Licens 22. Name and Address of Facility 415 E.Wilson Blvd., Hagerstown, Md. 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute MYOCARDIAL 12 HOURS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: as been signed by the attending 2 should be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) Medical KCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 333700 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 154 NORTH ARTIZAN ST. WILLIAMSPORT, MD egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:24 p. Robert Wayne Cannon May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18120 Copps Hill Place Montgomery Village Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Months Days 1 **X** M 2 □ F 06/16/1949 60 Yrs Director 219-52-1248 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland **Funeral Director** 1 XYes 2 No MD Montgomery Village Montgomery 10e. Street and Number 10g. Citizen of What Country? 23a 20886 18120 Copps Hill Place United States ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural" Completed 3 Divorced 4 Divorced Specify: white od 2 should be filed within 72 hours saith and Mental Hygiene. n 27 is marked other than "natura er traumatic event, the Medical E. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) manager retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Edward Cannon Annabelle Fulmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health an Important: If item 27 is any injury or other trau Garth Greenan/ personal rep <u> 182 Meserole St..</u> 2R. Brooklyn, NY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 🗶 Cremation 3 🗆 Removal from State Smithsburg Crematory 5/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, . Signature of Funeral Service Licensee 22. Name and Address of Facilit Keeney & Basford Funeral Home ule lie 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VIABETES disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence on if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sche Rusis 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an No the Hospital or Aux...
within 24 hours after death.

To the Funeral Director. After this certificate has the funeral director, page 2. performed? Yes 2 AN 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗌 Yes 2 🖪 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Medical Examines of the basis of examination and of involving the state of the cause of the ca only one) 29b. Signature and title of certifier 29c. License number 0716 W.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 541104 ALT7N 31. Date filed (Month, Day, Year) 32. Registrar'ş Signatur State

DHMH 17 Rev 7/2009

Registrar

JUN 0 3 2010

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24 Day Month 2010 **Physician** 0310 May Mary S. Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Frostburg Village Nursing Home Frostburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days MD 218-64-9524 Feb 19 1933 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medicel Eventine must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Garrett Swanton MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21561 1852 Chestnut Grove Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Friend George Beckman ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HC 80, Box 2169, Maysville, WV Lesia Crawford, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion, MD Mt. Zion Cemetery 05/27/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home, 710 Church St., Kitzmiller, MD 21. Signature of Funeral Service Licenses Katherine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RENAL Physician CHRONIC disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dull to (or as a consequence of) physician and s the burial-trans Physician/Medical Exam Due to (or as a consequence of): attending pt IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) been signed by the should be detached 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 sl autopsy performed 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, n 24 hours after death.

The Funeral Director: Af pletely filled in by the fur completely within 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Hellon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 925 Bishop Walsh Rd., Cumberland, MD Dr. Harjit S. Sidhu, 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 16, 2010 Edwin Alan Deutsch 2030 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗚 2 🗆 F Months Days Hours Min 127-26-8853 .N.Y. Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director MD Montgomery Olney 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17701 Lochness Circle 20832 USA 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No 1952

If Yes, Give

Year or Dates. Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Attornev Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Deutsch Ruby Meltsner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly LaCross/Wife 17701 Lochness Circle Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Crem. 1 Burial 2 Cremation 3 Removal from State 5/18/2010 Beltsville,Md 4 Donation 5 Other (Specify) PHITTPAD RINKLDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between vears Death Immediate Cause (Final Atherosclerotic cardiovascular disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any leading to immediate cause. Enter Underlying Cause (Disease or linjury for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical 5/16/10 IE EEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sepsis shock, urinary tract infection, Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown atrial fibrillation, hypertension, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performed? Yes 2 No death? dementia 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🔀 No ြုင 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year) May 17,2010 D53367 0 who completed cause of death (Item 23a) (Type, Print)
r Rajan M.D. 980! Georgia Avenue Silver Spring, Md 20902 30. Name and address of person in Shyamsundar 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anne Marie D'Alessio Month 1:15 A M May 15, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Rockville Examiner 4c. County of Death 11404 Empire Lane Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 193-30-3495 1 M 2 X F Months Days Hours Pennsylvania 1070871938 Yrs. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoi other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 x Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20852 11404 Empire Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Education Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Margaret Brady ည Howard Kennedy Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11404 Empire Lane Rockville, MD 20852 Richard D'Alessio/ Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 5/21/2010 National Crematory Falls Church, Virginia 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature o Funer Pervise Licens 5130 Wisconsin Ave. NW Washington, DC 20016 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter the disea Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Metastatic Adenocarcinoma Breast Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and ŭ Due to (or as a consequence of): burialattending physician Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? ō Month 5 Other (specify) Pregnant at time of death ed by the a g Unknown g Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate After this certifical funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🖺 Natural injury 5 Pending Jwithin 24 hours after death.

To the Funeral Director: Af completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal 29a, Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifie 29c. License number P 29d. Date signed (Month, Day, Year) MD21025 5/17/2010 Collect Strange 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Robert Warren MD 3800 Reservoir Rd. Washington, DC 20007

32. Registrar's Signature

18 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

		State of Maryland / I	Depa	irtment of Hea	alth and M	-	_	n 173	1 1
		State Registrar	Cer	tificate of De	eath		leg. No.	0 170	1 1
Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Dea Month	th Day	Year 3. Time o	of Death
/Medic		Nora Sue DeVore				May	4c. County	010 7:11	4 5.
Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo		0		hington	
3 · c _		8343 Neck Road 5. Social Security Number 6. Sex 7. Age (In yrs. last bi.	irthdav)		iamsport Under 24 Hrs.			9. Birthplace (State Country)	or Foreign
Funeral Director		525-54-0439 1 N 2KX 79	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day April 2	0,1931	New Mexic	CO
70		Usual Residence of Decedent						404 114-1	Cir. Limbs
arylar ahow	_	10a. State 10b. County 10c. City, Tow						10d. Inside (is 25No
he M.	ecto	Maryland Washington	W	illiamsport	<u> </u>		10g. Citizen of V		7121
with t	ā	10e. Street and Number			705				
Jeath ns 23	Funeral Director	8343 Neck Road 11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hispa f Yes, specify Cuban,	1795 anic Origin? (Spe	ecify Yes or No-		USA e - American Indian,	
after of the contract	교	1 Never Married XX Married 1 ☐ Yes 2XXNo				Hican, etc.)		k, White, etc.	
Sours s	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes No S	Specify:		Specify	wnite	
itled within 72 hours after death with the Maryland Hygiene. Utygiene. Uther than "natural", or Itams 23s or 28s-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done duri OO NOT use retired)	n ing most of worki	ng	16b. Kind of Bu	siness/Industry	
within then then	E C	Elementary/Secondary (0-12) College (1-4or 5+)		dical Mail:	ina Assi	stant	Publishir	rg and Book I	Binding
Hygin Hygin		17. Father's Name (First, Middle, Last)	1100		3. Mother's Name				
ic ave	To Be	Jack Jackson Spruill, Jr.			Lilla	V. Rog	ers		
ine, intally identified a 12 12 12 12 12 12 12 12 12 12 12 12 12				g Address (Street and					
and 2 and 2 ealth a n 27 is				Neck Road					
Pages 1 nent of Hourt: if Item				sition (Name of natory or other place)		ate		City or Town, State	
ment tant:				n Crematory			Hagerst	own, Mary	land
permit. Pages 1 and 2 Department of Health a Important: if itsm 27 is any injury or other tre anse.		21. Signature Tuneral Service Licensee		25 S. Cono			illi.ams	port, MD :	21795
		23a. Papa Enter the disease, or complications that caused the death. Do						Approxim	ate
Physician		Immediate Cause (Final	/	2 24 2 2 2				Onset and	d Death
/Medical	80	disease or condition resulting in death) a. Due to (or as a consequence		'ancer				65/	nonti v
Examiner		Sequentially list conditions b.							
D it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):						
be executed ician and burial-transit	хаш	resulting in death) Last C	of):						
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ificate g phy: as the	Physician/Medic	u.							
h cert endin	M/U	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	h 3	Ectopic pregnancy				te of delivery	V 025
o deat he att	sicie	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death		Other (specify)			Мо	nth Day	Year
d by t	Phy	9 Unknown	in the ur	adorhina cause awen	in Part I	23e Did to	bacco use cont	nbute to the cause of	f death?
signe Signe	þ	Part II. Other Significant Conditions Commoding to deal out not resouring	111 (110 01	Identiful de de de de de la company	iii raiti.	101	V		Unknown
w requir been si	Completed					24a. Was	an 24h	Were autopsy finding	rs available
he lav	dmo					autop perfo	sy med?	prior to completion of death?	cause of
ifficate or, pa	CC	25. Was case referred to medical		2	6. Place of Death	1 ☐ Yes	7	1 ☐ Yes 2 ☐ No	
ysicie s cert	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	utpatien	Other	4 ☐ Nursing Ho	3/	lence 6 Oth	er (Specify)	
ding Physician: The lav ding Physician: The lav h. After this certificate has funeral director, page 2.		(Month Day Voor)	Time of Injury	28c. Injury at Work?		28d. Describe h	low injury occur	ed	
andin Series	atto	2 Accident investigation			s 2 □No				
or Att fter d liract	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fi building, etc. (Specify)	arm, str	eet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	per or Rural Route Nu	ımber,
pital ours al		29a. Certifier Certifying Physician: To the best of my knowledge	a doath	a cooursed at the time	data and place	and due to the	rausa(s) and ma	anner as stated	
JOINSTOIL OF VIEW INCOMES, T.O. DON OUR TO the Hospital or Attending Physician: The law requires that the death certificate Bathin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicampletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only one) and manner stated.							∍(s)
Fo the Fo the compl	Me	29b. Signature and title of certifier		29c. License n	umber		29d. Date signe	d (Month, Day, Year))
45		His Hamila	MV	D46	473.		05/17	12010	
5		30. Name and address of person who completed cause of death (Item 23a)	(Туре,	Print)	01 00	- 1/	,	12010 DWN, MD	140.
		Flind Hamdon, MD	; 1	130 OF	16	1; HO	gerste	nwn, MD)
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		and I			\cup		
- AF	1947	MAI AD ZUIU Chamber A.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 11:30 A.M 2010 MAY Martine Gertrude EARLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington 7734 McClellan Avenue Boonsboro If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Oct. 29 Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year 1 □ M 2 🖔 F Maryland 82 1927 Director 220-82-3596 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, are Modical Examinational be notified at 1 ☐ Yes 2X No Director Boonsboro Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 7734 McClellan Avenue 21713 Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2\(\text{X} \) No 11. Marital Status Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No White Specify: ģ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Itel Magnee. College (1-4or 5+) Elementary/Secondary (0-12) 8 Homemaker Her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delores Clipp Martin Luther Butts ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7734 McClellan Avenue, Boonsboro, Maryland 21713 Vickie Sue Snyder - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park |5/17/10 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 415 E. Wilson Blvd. Hagerstown, Md. 21740 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARAN JYNNOME YEARS DAGANIC DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HISTORY OF BRAIN BOKEN OF if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit law requires that the death certificate be executed EREBROVAS WUAR Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MILOSOF autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pin 24 hours after death.

Funeral Director: After the Funeral Director is the funeral pletely filled in by 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760, completely To the within 2.

altimore, Maryland 21215-0036

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day,

FOX

DHMH 17 Rev 1/2001

and manner stated.

30. Name and address of person who completed pause of death (Item 23a) (Type, Print)

strar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

HACERSTOWN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P 010 MILDRED FOREMAN Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 6. Sex 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 Months Country) Maryland 90 **Director** 214-28-0974 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? 23a Funeral United States 21702 1421 Taney Ave., Apt.#611 or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal 1 Tes 2 No Specify. 3 XWidowed 4 Divorced Completed Year or Dates **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Cook 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cordelia Fassett Charles Pryor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1820 Meadow Grove Lane, Frederick, MD 21702 Raymond Foreman / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 5/29/2010 Ijamsville, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licen Stauffer Funeral Home 22. Name and Address of Facility Opossumtown Pike, Frederick, MD 21702 1621 23a. Rart 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cett brovascular Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O, Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death?

1
Yes 2 No 24a, Was an autopsy performe Yes 2 tor: After this certificate has the funeral director, page 2 s 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA မြ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1X Natural 5 Pending 2 🗌 No Investigation Accident 124 hours after deat e Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State)

State Registrar

To the within 2

Medical

(Check

only or 29b. Signa

31. Date filed (Month, Day, Year,

title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my calcium death occurred.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ May 12^{Day} 2010^{ear} 9:55 P Kenneth Ν. Flanagan Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Somerford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 1 AM 2 □ F **Funeral** Months Days Hours Min. Oct. 17, 1914 Alabama 95 Director 238-22-0807 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location at 10a. State 10h. County 10d. Inside City Limits with the Maryland Director Examiner must be notified 1 ☑ Yes 2 ☐ No Frederick Frederick Maryland 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 21702 2100 Whittier Drive items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. 3 □xWidowed 4 □ Divorced Specify "natural", Completed White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Construction Project Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Olar E. Davis Samuel G. Flanagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17609 S. 156th St., Springfield, NE 68059 Susan Snyder/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 TCremation 3 Removal from State Frederick, Maryland Stauffer Crematory 5/17/2010 4 ☐ Donation 5 ☐ Other (Specify) Stautfer Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that of shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death s been signed by the should be detached Unknown a Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ent ension Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed death? Yes 2 No Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) funeral director, examiner? Hospital Other: No No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 잍 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Certificate: 1 Natural iniury 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

DHMH 17 Rev 7/2009

State Registrar only on

29b. Signa

d title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

h on

Was Below

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year) 13/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1- State Amended #8 per	- 1	yland / Dep HD 5/19/				tal Hygie	ne 0 0	17315
	4. E. S.		Decedent's Name (First, Middle, Last)					2. 0	ate of Death		3. Time of Death
禁	Physici		Gertrude	Christine	Ferry				Month	Day Year 2010	12:00 P ^M
VE.	/Medic Examin		4a. Facility Name (If not institution, give s		relly	4b. City, To	own, or Location		ay 13	4c. County of Deat	
h	Examil	iei	9929 Moxley Road			D	amascus			Montg	omery
	Funeral		5. Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Months	Year If Under Days Hours	24 Hrs. 8. D	ate of Birth	O Bird	thplace (State or Foreign ountry)
	Director		065–16–7935	M 21X1F	87Yrs.	WIOITIIS	Day's Hours	Aug	ust 19	1344 Ne	w York
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	show	<u>.</u>	10a. State 10b. County		_						1 ☐ Yes 21 No
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	vith th	Director	10e. Street and Number			10f. Zip C			10g.	Citizen of What Co	
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	er de Itam	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 Xivo	or iii 0.3.	If Yes, specif	nt of Hispanic Or y Cuban, Mexica	n, Puerto Ricar	n, etc.)	Black, Whit	
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21215-0036	d within 72 hours after death with the Maryland jiele. r than "naturel", or Items 23a or 28a-f show the Medical Examiner must be motified at	ed	15. Decedent's Educ		16a. Dece	dent's Usual	Occupation		168	b. Kind of Business	/Industry
215	C 2 3	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	DO NOT use		st of working			
21	filed withi Hygiene. other than	Completed	12		Cus	tomer	Service			Banking	
	be filed ital Hygid of other event,	Be	17. Father's Name (First, Middle, Last)				18. Moth	er's Name (Fin	st, Middle, Mai	iden Sumame)	
<u> a</u>		10	Herbert Zimme	r			1	Mary Br	adley		
Maryland	and and sum	11	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Maili	ng Address (Street and Numb	er or Rural Rot	ute Number, C	ity or Town, State,	Zip Code)
	1 and 2 Heelth tem 27 other tra		Christine C. Davis				y Road,				0872
Baltimore,	of Hee of Hee if Item or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R		20b. Place of Dispo cemetery, cre	matory or oth	e of ner place)	Date	200	c. Location - City or	Town, State
Ĕ.	permit. Pages Depertment of h Important: If tte any injury or of		4 □ Donation 5 □ Other (Specify)		Gate of				2010 8	Silver Sp	ring, Md.
alt	permit. Depertr Importa any Inj		21. Signalure of Fun ral Service License	90	-) M	2. Name and oleswo	Address of Facili	^{ity} Liams P	.A. Fu	neral Ho	me
ш_	20529		Morent L.	Nille	am 2	6401 R	lidge Roa	ad, Da	mascus,	Marylan	d 20872
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the ne cause on each line.	e death. Do not en	ter the mode	of dying, such as	s cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Atheroso	elevotic	cardi	ovascula	r dist	ease		years
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):						
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	te be executed ysicien and ie burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):						
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×	leath certificate attending phy I for use as the	Physician/Medi	IF FEMALE: 2	3c. If yes, outcome of	pregnancy					23d. Date of de	livery
Вох	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim		□Ectopic pre				Month	Day Year
o.	at the de by the a tached	ysi	1 □ Yes 2 ☑No 9 □ Unknown	9☐ Unknown			7,				
<u>α</u>	ge g		Part II. Other significant conditions con	tributing to death but r	not resulting in the t	inderlying cai	use given in Part	I.	23e. Did tobac	cco use contribute t	o the cause of death?
ds	uires rign	d by	Diabetes						1 🗆 Yes	2 No 3□P	robably 4 Unknown
Vital Records,	w require	Completed	Rectal brolab	SP.					24a. Was an		utopsy findings available
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<u>ra</u>		Ö	25. Was case referred to medical				26. Plac	e of Death (Ch		SINO 1 10.	
S	Physician: r this certific ral director.	To B	examiner?	lospital: 1 ☐ Inpatient	2 ER/Outpatie	nt_ 3 DOA	Other		11	e 6 □Other (Spe	əcify)
of	g Phy er thi		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time o		c. Injury at Work?	28d.	Describe how	injury occurred	
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Division	at or Attending Pt s after death. ii Director: After the sd in by the funeral	ific	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, st	reet, factory,	office		Location (Stree		lural Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune			Meian: To the bast of n							
	the H in 24 the F iplete	ledicai	one)	and manner stated	j.						
	With To I	Σ	29b. Signature and title of certifier	B. M.	u Ma A		License number	0	29d	Date signed (Mon	on, Day, Year)
			Fatticid 10 m	2100 /10	1) 1110		D51916	>	///	144 13	2010
-	-		0. Name and address of per in who co	mpleted cause of deat	h (tem 23a) (Type	Print)	-100 P.	Lille	hat.	10050	
6.7	5	Ш	Patricial Jamsko W	32. Registrar's	Signatura #	15,6	-100, Roc	KVIIIE,	11/16	LVO D'X	
**************************************	Sta Registr		31. Date filed (Month, Day, Year)	2010 Len	SUAL A	A CON	100				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Rita R. Forman 2010 7:30 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Home Rockville Montgomery If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2**火**□ F 010-03-9387 101 Director 08/05/1908 Boston, MA Usual Residence of Decedent Maryland #10 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ust be notified at 1 X Yes 2 ☐ No Director MD Montgomery Rockville 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 23a or Apt.#916 6111 Montrose Road 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or items 11. Marital Status other traumatic event, the Wodical Examination 72 hours after □Yes 2 XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White þ 3 XWidowed 4 ☐ Divorced Year or Dates: natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Department Store marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Lewis Egelnick Mary Goldberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Ellen H. Rosenthal / daughter 11759 Gainsborough Road Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)

Star Of David Memorial Gardens

O5/18/2010 North Lauderdale, FL 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any Injury or 21. Signature of Funeral Service Licensee Edward Sage1 22. Name and Address of Danizansky-Goldberg Memorial Chapels M00910 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and-tran Due to (or as a conseque burial-t physician the burial Box 68760. death certificate be Physician/Medical attending p as IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 Other (specify) ned by the a □Yes 2XXNo Ö 9 Unknown 9 Unknown signed by to ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Deatl 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural s after dea. 1 □ Yes 2 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 hor To the Fune (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature apd-၉ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive; Rockville, MD 20855 Ahmed Heshmat, M.D.; 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 18

DHMH 17 Rev 1/2001

Registrar

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	Physicia	n/	1. Decedent's Name (First, Middle, Lasi	t)					2. Date of Dea		ay 2010 Year	3. Time of Death		
	Medic Examin		Bernice Forgosh 4a. Facility Name (if not institution, give:	street and number)		4b. Cit	v. Town, or Lo	ocation of Death	May 10		c. County of Death	1 1900		
-18	LXAIIIII	GI	Shady Grove Adven		1		ockvil				Montgome			
	Funeral Director		125-14-3410	7. Age (In yrs	last birthday) Yrs.	If Und Months		f Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da Feb	h v. Year) 24 •	9. Birth Cour 1925 New	place (State or Foreign htry) York		
/Dik	how how	1 1	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation						10d. Inside City Limits		
	Aaryla 8a-f s tified	Funeral Director	MD Montgome	ry	Silver	Spri	ng					1 ₺ Yes 2 □ No		
	a or 2	Ö	10e. Street and Number				ip Code			10g. C	itizen of What Cou	intry?		
	ns 23 must	ner	15115 Interlachen					0906		U.S.A.				
980	e filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	۵	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.			edent of Hisp ecify Cuban, 2 🛣 No		ecify Yes or No- Rican, etc.)		can Indian, etc. te			
Maryland 21215-0036		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Seconday (0-12)	fucation	(Give	kind of w	ual Occupations done dur se retired)	on ing most of wor	king	16b.	Kind of Business Ir	-		
2	illed within 72 al Hygiene. I other than "	lool	12				Homem				Own	Home		
and	ntal Hy red oth	10 B	17. Father's Name (First, Middle, Last) David Sumergrade				1		ne <i>(First, Middl</i> e, Motchan	le, Maiden Surname)				
Ž	should be filk and Mental is marked of aumatic eve		19a. Informant's Name/Relationship (Ty	pe, Print)	I 19h Maili	na Addre	ss (Street and		-City o	or Town, State, Zip	Code) 20876			
N N	d 2 sh alth ar n 27 is ertrau		Errol Forgosh/Son		1211	0 Mi	leston	e Manor	Lane,	έΠ	nantown hersberg	code) 20876 • Maryland		
Baltimore,	Page 1 and 2 should be nent of Health and Men ant. If item 27 is marke iny or other traumatic		20a. Method of Disposition 1 3 Brurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dispo cemetery, crei	matory or	other place)	nce 5/1	Date 2/2010		Location - City or T Larksburg			
Balti	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		Garden of Remembrance 5/12/2010 Clarksburg, 21. Signature of Funeral Service icensee M01597 22. Name an Estimated FaStagel Funeral Direction, Welissa Greenhut 1091 Rockville Pike, Rockville, Maryla											
F	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	olications that caused the de ne cause on each line. Sepsis	ath. Do not ent	er the mo	ode of dying,	such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death Day		
	Medical Examiner		resulting in death)	Due to (or as a conse Aspiration		moni	а					1 Day		
		iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury	b. Due to (or as a conse										
	be executed sician and burial-transit	Examiner	that initiated events	Due to (or as a consequence of):										
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	cate b physi s the b			d						_				
Вох	e death certificate the attending physhed for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live Birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	☐ Ectopi	c pregnancy (specify)				23d. Date of deliver Month	very Day Year		
s, P.O.	requires that the de been signed by the should be detached	d by Ph	Part II. Other significant conditions co	ontributing to death but not r	resulting in the	underlyin	g cause giver	n in Part I.				the cause of death?		
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Vita	ysicia is cert direct	To B	examiner? 1 Yes 2 No	Hospital: 1 🔀 Inpatient 2	☐ ER/Outpatie	nt 3 🗆	DOA Other:	4 Nursing H	lome 5 Resid	dence	6 ☐ Other (Specif	5)		
of	ng Ph fter th ineral	ate:	27. Manner of Death 1 😾 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time o injury		28c. Injury a work?		28d. Describe h	now inju	ury occurred			
Division of Vital	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			M reet, facto		es 2 No	28f. Location (S City or Tov		nd Number or Rure e)	al Route Number,		
_	ne Hospita In 24 hours ne Funeral pleted filler	Medical	(Check 2 Medical Exami	sician: To the best of my kno ner: On the basis of examinat se Practioner: To the best of	tion and/or inves	stigation, i	n my opinion,	death occurred	at the time, date a	and plac	ce, and due to the ca	ause(s) and manner stated.		
	vithi To #		29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon								ate signed (Month,	Day, Year)		
	25		Magnet	M.D.			006	9759			טוןויןפ			
			30. Name and addres of person who can belay Woldegi	·			odica1	Contor	Drivo	Roo	kwillo	MD 20850		
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Sign		OI FI	curcar	Center	DITVE	KUC	VATTTE?	1 LOOJO		
	Registr	ar	報AY I 8 7010	1 Va Dad .	M MOON	100								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 5:14 AM 2010 Miriam Physician/ Fitleberg Zella Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner FREDERICK Mount Airy Kline House Hospice 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea 01/6/1936 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Canada Days **Funeral** Hours 1 🗆 M 2 🗶 F 74 **Director** 550-66-6234 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County should be filed within 72 hours after death with the Mary/and and Mental Hyglene. 'Is marked other than "natural". or items 23a nr 28a-1 ehr 10a. State Director 1 Yes 2 🗌 No Frederick MD FREDERIC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21704 9413 Bishopgate Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give þ 1 ☐ Yes 2 No Specify: Specify: WHITE Baltimore, Maryland 21215-0036 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Banking Elementary/Seconday (0-12) Teller 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) 2 Ray Kastner Jacob Hillman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9413 Bihsopgate Drive Frederick MD 21704 permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trausonce. Bonnie Fitleberg - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Mission Hills, CA cemetery, crematory or other place)
GROMAN EDEN Park 05/21/2010 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Edward Sage Funeral Direction Inc. 1091 Rockville Pike Rockville MD 20852 Signature of Funeral Service Licences M01163231 For 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Voler Immediate Cause (Final disease or condition BREAST CANCER METASTATIC Physician/ resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): and -transit The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): the burial attending physician Physician/Medical Box 68760 use as 1 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year Day Month ed by the attent detached for u in the past 12 months?
1 Yes 2 No 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed the should be determined to the should be dete 2 No þ 3 Probably 4 Unknown 1 Tyes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform 2 🗌 No 1 Tes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? or Attending Physician: Be Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Hospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No 1 🗌 Yes ျှ 24 hours after death. Funeral Director: After this 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hospital Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
The cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifie

To the within 2 To the F Tol 10 State Registrar

30. Name and address of person who complete

9

31. Date filed (Month, Day, Year)

2. Registrar's Signature

0069273

5-18-2010

MD Frederick MD 21704 Blvd #103

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Harold Elmer FRALEY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Washington Hagerstown 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 ★ M 2 ☐ F If Under 24 Hrs. 8 Date of Birth e of b... inth, Day Y 9. Birthplace (State or Foreign Funeral Year) 19<u>23</u> Months Min Feb. Maryland Director 87 215-14-2103 Usual Residence of Decedent 23a or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11535 Englewood Drive 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 🔀 Yes 2 🗆 No If Yes, Give 1946-47 Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 M Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) 6 Tool & Cutter Grinder Truck Mfg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Fitem 27 is marked c မ James Baker Fraley Lucy Annie Spielman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Fraley - Son 836 Rose Hill Avenue Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 5/20/10 Hagerstown, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, MD. 21740 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 218937 Physician/ Medical Due to (or as a consequence of): Examiner ES PIRATORT FAILUNE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical OBSTRUCTIVE LLMONNEY DISEAJE Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Mullinknown Records, has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 💆 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Decritiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1006200 C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANID ANTI GAM ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 15^{Day} 2010 3:45 A GRACE GIFFORD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 25 1924 Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🔀 F 85 Director 219-22-5438 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f HARFORD FOREST HILL 1 Tes 2 No MD ŏ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 109 FOREST VALLEY DRIVE 21050-2831 USA items filed within 72 hours after death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc ō à 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Yes, Give Specify: "natural" Completed 3 Widowed 4 Divorced WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ANNA CLAUDIA HOOVER GEORGE A. HEDRICK Department of Health and Mt Important: If item 27 is mark any injury or other themsone. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 884 BARNES CORNER RD. RISING SUN, MD 21911 FLORENCE PALMER/ DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/18942010 Burial 2 ☐ Cremation 3 ☐ Removal from State ST.ABRAHAMS LUTHERAN CEMETERY BECKLEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens •I• FOARD FUNERAL HOME, S. QUEEN ST. RISING SUN, MD 21911 23a. Part 1 Enter the disease, or complishock or heart failure. List only one Immediate Cause (Final ns that ca sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events requires that the death certificate be executed burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as the l IE EEMALE nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Month Day Year 1 ☐ Yes 2 B 9 ☐ Unknown detached Division of Vital Records, P.O. þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Inpatient 2 I ER/Outpatient 3 DOA To the Funeral Director: After this completed filled in by the funeral directions. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 2 🗌 No 1 Yes Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 WEST MACPHAIL ROAD BEL AIR, MD. 21014 DAVID DIINN 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

MAY 18 2018

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of M	laryland / D				lental Hy	giene	510	
			Registrar		Cert	ificate of D	eath		Reg. No. 2		1/321
	Physicia	n/	Decedent's Name (First, Middle, Last)					2. Date of De Month May 15		Year	3. Time of Death 8:15 a M
	Medic		Garlen Gulley Jr. 4a. Facility Name (if not institution, give street and number)			4h City Town or	Location of Death	ray 13		nty of Death	
,,,	Examin	er	Montgomery Hospice Casey	louse		Rockvi				tgome:	
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birth		If Under 1 Year		8. Date of Birt			pplace (State or Foreign
	Director		404-32-4151 1 XM 2 □ F	82 Y	rs.	Months Days	Hours Min.	May 8,	, Year) 1928	Ken	tucky
	d Now	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Loca	ation				T	10d. Inside City Limits
	arylan a-f sk fied a	cto	Maryland Montgomery	Gaithe							1 ☐ Yes 2 🎦 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?
	with the 23a st be	Funeral	101 Odendhal Avenue			2087	7	İ	USA		
	tems rems	Fun	11. Marital Status 12. Was Decedent Armed Forces		13. W	as Decedent of His	spanic Origin? (Spo	ecify Yes or No-		Race - Amer	
36	", or	þ	1 Never Married 2 1 Married 1 1 X Yes 2	No No		Yes 2 XNo				Black, White cify: Whi	
Ö	ours atural	Completed by	3 Widowed 4 Divorced Year or Dates.	1951-1953	Docode	nt's Usual Occupa	ation		16b. Kind o		
75	72 h an "na Medic)du	(Specify only highest grade completed)		Give kir		uring most of work	ing	16b. Kind 6	i Business ii	idustry
21215-0036	withir giene er tha		Elementary/Seconday (0-12) College (1-4 or		nds	caper			County	Gove	rnment
пd	filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last) Garlen Gulley				18. Mother's Nam	e (First, Middle, e Likin		ame)	
уlа	Meni Meni narke	ř									
Mag	1 and 2 should be filed within 72 hours after death with the Maryland of Heatth and Mental Hygiene. The matter and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	al Route Numbe	-						
e,	and 2 Healt tem 2		Mary McCausland / Daughte: 20a. Method of Disposition	20b. Place of			er Drive	Date Rensi	20c. Location		
nor	Page 1 ment of ant; If it ury or o		1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	9)	8, 2010	Rockvi.	-				
Baltimore, Maryland	permit. Page 1 Department of Important: If i any injury or once.		21. Signature Funeral Service Licensee		22	Name and Addres	s of Facility				
Ä	Der Jany		X blest X)	500	ncis J. Univers	Collins ity Blvd	Funeral	Home, Silver	Inc. Spri	ng, MD 20901
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir				Approximate Interval Between				
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	Medical Examiner		resulting in death) Due to (or as								
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876	ifficate ng phy as th	Med	IF FEMALE:								
Ø ×	eath certifica attending p	ian/	23b. Was decedent pregnant 23c. If yes, outcome 1 Live Birth	2 Fetal death		Ectopic pregnanc	у			Date of deli Month	
Division of Vital Records, P.O. Box 687	e deat the at ned fo	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown	at time of death	5 📙	Other (specify)				MOULT	Day Year
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ord	requipers	Completed by						24a. Was		b. Were aut	opsy findings available
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ξ	nysici nis ce direc	To E	examiner? 1 Yes 2 No Hospital: 1 Inpa	ient 2 ER/Out	patient	3 ☐ DOA Othe	r: 4 🗆 Nursing H	ome 5 Resid	dence 6 🛣 (Other (Speci	W Hospice
1 Of	ing Pl		27. Manner of Death 28a. Date of inj (Month, Di (Month, Di		me of jury	28c, Injury work	? _	28d. Describe h	ow injury occ	urred	
ioi	ttend death stor: A the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	jury - At home, farr	n stree		Yes 2 □ No	28f Location /9	Street and Nu	mher or Rur	al Route Number,
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	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 Certifying Physician: To the best of								
	he Ho iin 24 he Fu iplete	Mec	(Check 2 ☐ Medical Examiner: On the basis of only one) 3 ☐ Certifying Nurse Practioner: To the	examination and/or best of my knowle	investig edge, de	ation, in my opinio ath occurred at the	n, death occurred a time, date and pla	t the time, date a ce, and due to th	e cause(s) and	manner as	ause(s) and manner stated.
			29b. Signature and title of certifier			29c. License			29d. Date sig		Day, Year)
	3+1		186 H.D.				07020	8	5/15	12010	
-			30. Name and address of person who completed cause of Eliezer Soto, MD 10 Cente:				hesda. M	D 20892			
	Stat	e									
F	Registra		MAY 18 2010 Janua	rar's Signature		,					

1 - State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Day Month **Physician** 2010 8:00 A M David Eugene Gaines May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 423 North Jonathan St. Hagerstown Washington County If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 X M 2 □ F 219-60-4607 56 Mary Land 14, 1953 Director Nov. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b Counts 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f sho event, the Madical Examinar must be routhed at 1X Yes 2 □ No Maryland Washington County Director Hagerstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 423 North Jonathan St. 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Whit Be Completed by 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item Library Maintance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Dennis Gaines, Sr. Sara Catherine Rideout Gaines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Gaines-wife 423 North Jonathan St. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Denial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 5-24-2010 Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 roni 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (ONGEITINE HEAD? PAILUSTE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): the for use as Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. a T Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an certificate has autopsy performed? 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient . ₽R/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tina of certifier 29c. License number 222313 5-20-10 MO 624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 21742 OakHill 32. Registrar's Signature 31. Date filed (Mor av. Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State PR	aryH affe	•	ਸ਼ੇਮੀੀeਿਐ/df\ਮ tificate of D		Mental Hy		0010	h she	
			Decedent's Name (First, Middle, Last))	_		inouto or b		2. Date of De	Reg. No.	287 6	3 Time	of Death
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			Montgomery Hospice	Casey Hot	ıse		Rockvi			М	ontgom	ery	
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Maryland 21215-0036	be lined within 7.2 bours after death with the Maryland ential Hyglene. Red other than "natural", or items 23a or 28a-f show ked other the Medical Examiner must be notified at its event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates.	No		Yes, specify Cubar ☐ Yes 2 X No		Rican, etc.)	S	Black, White pecify: Wh	e, etc. ite	
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Baltimore,	permit. Cage I aim of Should be in Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service License		MO1477	22.	Name and Address	s of Facility	al Dire	0+10	Tno		
ш ;	70 = 20	Ц	4 mil	The		10	Name and Address dward Sag 91 Rockvi	lle Pike	Rockvi	11e.	MD 208	52	
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Box death c	atter I for u	Physician/M	in the past 12 months? 1 Yes 2 X No	1 Live Birth 2 4 Pregnant at 1	Fetal dea	ath 3 🗌	Ectopic pregnancy Other (specify)			23	3d. Date of del Month	very Day	Year
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SIO	r dear	ŧ	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	y - At home, i	farm, stree			28f. Location (S	Street and I	Number or Rur	al Route Nun	nber.
DIVISION Of VITAI HECOFUS, tal or Attending Physician: The law requires	s afte		4 - Homicide determined	building, etc.					City or Tow		va		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
e Hospit	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 X Certifying Physic (Check 2 Medical Examina only one) 3 Certifying Nurse	cian: To the best of mer: On the basis of exa Practioner: To the be	amination and	or investic	ation, in my opinion	 death occurred at 	the time, date a	nd place, a	nd due to the c	ause(s) and n	nanner stated.
To th	within comp		29b. Signature and title of certifier	1		-33, 40	29c. License				signed (Month		
	25		15 dy	h			D60	634		Mav	14, 20	10	
'			30. Name and address of person who cou	npleted cause of dea	ath (Item 23a)	(Type, Pri	_					-	
			Bindu C. Joseph M		Varnum	Stre	eet #021	Washingt	on DC 2	0017			
	State Registra	_	81. Date filed (<i>Month, Day, Year</i>) MAY 19 2010	2. Registrar	s signature	Stre					_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of	of Maryla			lealth and M	lental Hy	giene		
		1 - State Registrar			Cer	tificate of I	Death		Reg. No.	110	17321
Physi	cian	Decedent's Name (First, Middle	e, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
/Med			O. Hanl		•	# O't T	- Landing of Dooth	May	-	010 ty of Deat	4:10 A.
Exam	iner	4a. Facility Name (If not institution		·	_		r Location of Death			•	11
F		Moran Mano	6. Sex		e rs. last birthday)		If Under 24 Hrs.	8. Date of Birt	h	eg. 9. Birt	hplace (State or Foreign
Funera Directo		235-56-3757	1 ∑ M 2□F	74	Yrs.	Months Days	Hours Min.	(Month, Da) 2-21-	y, <i>Year)</i> 36		uintry) WV
Ð		Usual Residence of Decedent		140- /	0% T						10d. Inside City Limits
arylar show d at	_	10a. State 10b. County			City, Town or Lo						1√□Yes 2□No
he M.	Director	MD Alle	∍ g		Wester	10f. Zip Code			10g. Citizen o	f What Co	Λ
with t		10e. Street and Number 219 Spruce	St			2156	52		USA		andy.
feath ns 23 musi	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13. \	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No	. 14. R	ace - Ame	rican Indian,
or Iter	Ţ	1 ☐ Never Married 2 ☐ Mar	ried Armed F	20 No			an', Mexican', Puèrto Specify:	Hican, etc.)		lack, White	
ral", c	Ş	3 Widowed 4 □ Divorced	Year or I			1 □ Yes 2√√ No	Specify.			oify: Wh	
72 h "natu	Completed	15. Deceder (Specify only highe	it's Education est grade completed)		(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing	16b. Kind of	Business/	Industry
within ene.	am a	Elementary/Secondary (0-12)	College	1-4or 5+)			" . Operat	or	Westv	raco	Corp.
Hygin Hygin Sther		17. Father's Name (First, Middle,	Last)			,	18. Mother's Name		-		00-10-
lid be lental ked c	To Be	Austin Hanl	in				Ruth	D. Wil	.t		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28e-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Rui	al Route Numb	er, City or Tow	n, State, 2	Zip Code)
1 and 2 Health tem 27 i		Austin Hanli	n - Son		219	Spruce	St, Wes	ternpo	ort, M	D 21	562
S Titer C		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from		. Place of Dispo cemetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location	,	
Pag tmen tant:		4 □ Donation 5 □ Other (5	Specify)		carpel		5-2	3-10	Cresa	otow	n,MD
perilling 15, 1941 yially 212.15.10000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other fraumatic event, the Medical Examiner must be notified at	a)	21. Signature of Funeral Service	Lice See	112			ss of Facility Fr				
		23a. Part1. Enter the disease, o	r complications that	caused the de	eath. Do not ent	1 Jones er the mode of dvir	ST. Pi	edmont or respiratory a	rest.	267	Approximate
		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.							Interval Between Onset and Death
Physiciar /Medica		disease or condition resulting in death)	a. Due to	(or as a cons	equence of):	Jungles De (La barre	*/^			3 hours
Examine				10,20	very 1	stay	Infanti In sum				unlenous
16 ²	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or as a cons	equence of):						
ecuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С	-							
cate be executed physician and the burial-transit			Due to	(or as a cons	equence or):						
icate l	dical		d								
The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou						23d. I	Date of de	livery
death atter	ciar	in the past 12 months?	4□Preg	birth 2□Fo nant at time o		Ectopic pregnancy Other (specify)	<i>y</i>			Month	Day Year
the cy the achec	hvs	9 Unknown	9□Unkr	nown							
w requires that the do been signed by the should be detached	by P	Part II. Other significant conditi	ons contributing to	leath but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use co		the cause of death?
equire en sig		thy reve	としらいい					10	Yes 2□ No	3 □ P	robably 4 Minknown
law r las be	Completed	chimic	obstr	netiv	plater	on ory	Piscosi	24a. Was auto	osy	prior to	utopsy findings available completion of cause of
The cate the page	Son					· · · · · · · · · · · · · · · · · · ·		pend 1□ Yes	rmed?	death? 1 ☐ Yes	2 □ No
vican iclan certifi	Be	25. Was case referred to medica examiner?	Hospital:			Oth	26. Place of Deat				
Phys rthis	2	1 ☐ Yes ANNO 27. Manner of Death	28a. Date		ER/Outpatier	I 3 DOA	4 🖾 Nursing Ho	ome 5 Resi			ecify)
Afte fune	tion	Natural 5 ☐ Pendir 2 ☐ Accident investi	ng (Moi	nth, Day Year)) Injury	f 28c. Injur Wor M 1 🗆	k? Yes 2 □ No				
Atter r deal ector by the	fica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ainad 20t. Flat	e of injury - At	t home, farm, str	eet, factory, office		28f. Location (Street and Nu	mber or R	ural Route Number,
s after safter bit Dir	Certification:	4 - Hornoide	Duik	ing, etc. (ope				Only of 1 of	vii, Otato)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	edical ((Check only 2 Medical	ng Physician: To the Examiner: On the	basis of exam							
thin 24 the I the I	Medi	one)	and ma	nner stated.		29c. Licens			29d. Date sig		
₽ ₹ ₽ 8		1							,	,	
51		30. Name and address of person	who completed car	se of death /It	tem 23a) (Tyne	Print)	2 44		3/21/	201	
	3	DR TEGUS TA	11 -41	BROAD	1/ Will	FROST	BURK.	MD. 3	2/532	7	
9	State	31. Date filed (Month, Day, Year,	who completed cau 2 4 2010	Registrar's Sig	gnature	11	14 / 3				
Regis	strar	MAY	24 ZUIU	Cenn	1 B. A	race					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month MAY 2010^a 14, 1415 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Homewood-Crumland Farms 7407 Willow Frederick 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 06-01-1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 F State College, PA 178-07-6694 Director 1.0 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No r 28a-f sh notifled Prince Georges Laurel Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code "natural", or Items 23a or 20707 U.S.A. 13501 Birkhall Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 Elementary/Secondary (0-12) College (1-4or 5+) Communications CLerk U.S.Govenrment 18. Mother's Name (First, Middle, Maiden Surname)
Mabel Rebecca Shuey 17. Father's Name (First, Middle, Last)
John Calvin Homem Maryland t and 2 should be the Health and Mental I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13501 Birkhall Drive Laurel, Md. 20707 Ellen L. Shatzer/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Centre Memorial Park 5/19/2010 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: If it any injury or State College, PA 21. Signature of June al Service Licersee ROBERIO Édire DAILEY & SON FUNERAL HOMES, P.A. A feel 1201 N. Market St. Frederick, Md. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, liv one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or liquity that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1∏ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospina. c. within 24 hours after death.

To the Funeral Director: After this c 2 No 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 2 ō 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D0055061 completed cause of death (Item 23a) (Type, Print) 300 WEST NINTH STREET, FREDEZICE, MD 21701 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	State of Maryland / Dep	artment of Health and Nartificate of Death	Mental Hy	2010	1 17326			
Physician/		Registrar 1. Decedent's Name (First, Middle, Last) Daniel Raymond Halsey, Sr.	imode or Bodin	2. Date of De Month May 17		3. Time of Death			
Medical Examiner	1	ta. Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	May 17	4c. County of Dea Montgon				
Funeral Director	4/	6. Social Security Number 224-56-4913	if Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da Feb. 2	th g. Bir ay, Year) Co 20, 1943 Vii	rthplace (State or Foreign ountry) cginia			
laryland 3a-f show ified at ector	_ h	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Montgomery Silver	position Spring			10d. Inside City Limits 1 ☐ Yes 2 ※ No			
leath with the Marylanc items 23a or 28a-f she er must be notified at Euneral Director	בומו	10e. Street and Number 9700 Admiralty Drive	10f. Zip Code 20910		10g. Citizen of What Country? USA				
은 노녀 >	3	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh 1	te, etc.			
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of any injury or other traumatic event, the Medical Exam once. To Be Completed by		(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work OO NOT use retired) nanic	ing	16b. Kind of Business				
/land // d be filed v Mental Hyg arked othe attic event,		17. Father's Name (First, Middle, Last) Raymond Halsey	18. Mother's Nam Ethel K		Maiden Sumame)				
e, Marylanc and 2 should be file Health and Mental I lem 27 is marked o ther traumatic eve		Faithe A. Halsey / Wife 970	ing Address (Street and Number or Rura D Admiralty Drive,						
Baltimore permit. Page 1 a Department of H Important: If ite any injury or ott		4 Donation 5 Other (Specify) Metropolit	matory or other place) an Crematory May 1		20c. Location - City of Alexandria, V	irginia			
Balk permit Depar Impor any in		21. Signature of Funeral Service Licensee	2 Name and Address of Facility Francis J. Collins 500 University Blv	Funera	al Home, Ind Silver Spi	ring, MD 20901			
Physician/			ter the mode of dying, such as cardiac of Cancer, Metastatic		rest,	Approximate Interval Between Onset and Death			
Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions.							
xecuted n and l-transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.			_				
60 tte be e: hysiciar he burit		resulting in death) Last Due to (or as a consequence of): d							
ox 68 ath certific attending for use as	- 4	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	olivery Day Year			
교 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등	נו ני	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		obacco use contribute to	o the cause of death?			
Division of Vital Records, lal or Attending Physician: The law requires rs after death. In Director. After this certificate has been signed in by the funeral director, page 2 should be to Certificate: To Be Completed to					psy prior to ormed? death?	utopsy findings available completion of cause of			
Vital hysician: nis certific I director,		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 No ER/Outpatient 2 ER/Outpatient	26. Place of Death (Check		dence 6 Other (Sner	nifu)			
Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s Medical Certificate: To Be Compl		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury		_	lesidence 6 Other (Specify) be how injury occurred				
Divisi		3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		on (Street and Number or Rural Route Number, Town, State)				
the Hospita nin 24 hours the Funeral npleted filled		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inversion only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a death occurred at the time, date and place	the time, date	and place, and due to the	cause(s) and manner stated.			
3	2	29b. Signature and title of certifier Yhpuse	29c. License number D0069288		29d. Date signed (Monte) May 17, 201				
	3	30. Name and address of person who completed cause of death (Item 23a) (Type, Yodit Woldemichael Negusse, MD 3145	· ·						
State Registrar	3	MAY 18 2010 Lenus A. Aar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#26perMD,5/18/10,BMW,MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Anna Horn 2010 A^{M} May 14 8:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8146 Claiborne Drive Frederick Frederick 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth (Month, Day, Year) 03/25/1911 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 □ M 2 **X**] F Director 163-05-8256 99 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 6351 Spring Ridge Pkwy. #304 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Heeneke Catherine Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8146 Claiborne Drive Frederick, Maryland. 21702 Suzanne H. Morders (Daughter) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 5/21/2010 | Cheltenham, PA Holy Sepulchre Cem. 22. Name and Address of Facility Signature of Funeral Service DeVol Funeral Home MD.10 East Deer Park Drive Gaithersburg, 20877 Sa. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.

The diagram of the disease of condition

Small Bowel Obstmetry Approximate Interval Between Onset and Death Small Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner heele cute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Oaugnter's residence (X) Other (Specify) Hospital: 4 Nursing Home 5 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be within 24 hours after death

Vo the Funeral Director: Appropriate of Illed in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 2 5-14-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tou House Auc. Frederick. 801 Zaidi MO 31. Date filed (Month, Day, Year)

MAY 18 2010 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 2010 Month Robert Francis Hohman **Physician** May 17, 6:10 AM /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Gaithersburg Wilson Health Care Center 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year)
March 19,1921 Pennsylvania If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 174-12-2907 **Funeral** Hours 1 XM 2 □ F Months Days 89 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🖺 No North Potomac Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20878 12625 Lloydminster Drive Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ NoWorld If Yes, Give Year or Dates: War II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Hohman Frank Hohman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12625 Lloydminster Drive, N. Potomac, MD 20878 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau (Son) Robert J. Hohman 20b. Place of Disposition (Name of cemetery, Grematory of other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State May 21,2010 Triangle, Virginia National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral 10 E. Deer Park Drive, Gaithersburg, MD 20877 M00689 Approximate Interval Between Onset and Death Part 1.Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, specific heart failure. List only one cause on each line. Immediate Cause (Final re mouth uneto1 Physician disease or condition resulting in death) /Medical Due to (or as a cons suence of): Examiner varres Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine signed by the attending physician and it be detached for use as the burial-transit Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 2 1 No 1 🗌 Yes should t Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No certificate strunin 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After thi 27. Mann of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 04115 14. Riheet Dischla 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RUSSELL A 44174ERSOURE 11.ROBERT BIRSCHOACH ALL 31. Date filed (Month, Day, Year) 62. Registrar's Signature 19 **ORIGINAL**

State

7+

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05712/2010 JAMES EDWARD HOES 12:01 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 437 W. Diamond Avenue, #101 Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 □ F Hours 09/09/1950 219-54-7629 Director 59 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 □ No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 437 W. Diamond Avenue, #101 20877 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 XNever Married 2 Married 1971 Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced 1973 Specify: Black Year or Dates Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12th Disabled None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ernest Hoes, Jr. Marsha Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Page 1 and 2 Rudolph Hoes - brother 1630 West Old Baltimore Road. Boyds, MD 20841 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1. Department of Important: If it ŏ cemeters, crematory or other place 1 ☐ Burial Marcration 3 ☐ Removal injury or 4 Dog n 5 Other (Specify) Ardent dremation Svc 5/18/10 Hanover, MD 21. Signatur of uneral Service Lic 2. Name and Address of Facility Snowden Funeral Home any 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician. Acute cardiorespiratory failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Chronic hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) requires that the death certificate be executed -transit Cause (Disease or iinjury Liver cirrhosis that initiated events resulting in death) Last Due to (or as a consequence of): burial physician the burial Physician/Medical Encephalopathy Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown been si Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 autopsy performed? Yes 2 AN death? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c} \mathbb{X}\) Residence 6 \(\sum \) Other (Specify) Hospital: ဂ္ 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: Aft oldeted filled in by the fur Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifie

Registrar

State

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Shukla Gomez

19

31. Date filed (Month, Day, Year)

D63232

15225 Shady Grove Road, #208, Rockville, MD 20850

5-13-2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Shirley Ann Soltis Hardinge Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 13253 Fountain Head Road Hagerstown Social Security Number If Under 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 1 □ M 2 🛛 F Months Days Min. 184-12-2949 87 Yrs Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director MD Washington Hagerstown 10e. Street and Numbe 10f. Zip Code "natural", or items 23a or edical Examiner must be Funeral 13253 Fountain Head Road 21742 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 ☐ Yes 2 🔀 No ð 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Vice President/Secretary Ith and Mental Hygie 27 is marked other traumatic event, tl Be 17. Father's Name (First, Middle, Last) 1 and 2 should be fil f Health and Mental item 27 is marked ၉ Henry Adelarde Conner 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and Department of Heatt Important: If item 27 any injury or other tra Thomas H. Hardinge / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematorium Signature of Euperal Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pancreas Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No 9 Unknown Pregnant at time of death g Unknown as been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, page certificate l 25. Was case referred to medical examiner? Division of Vital funeral director, Be Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Hospital or Attending Natural Accider 5 Pending injury after death. 2 Accident 3 Suicide 4 Homicide Investigation the 6 Could not be To the Hospital or Atter within 24 hours after de To the Funeral Directo 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier (Check

May & Mill

18. Mother's Name (First, Middle, Maiden Surname) Leah Edna Scadden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13253 Fountain Head Road Hagerstown, MD 21742 20c. Location - City or Town, State May 19,2010 Smithsburg, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Pot<u>omac St. Hagerstown, MD 21740</u> Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 No Yes 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature ORIGINAL

Reg. No.

USA

2010

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business Industry

Automotive Sales

14. Race - American Indian,

White

Black, White, etc.

Washington

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 🏝 No

MarvTand

11:42 AM

2. Date of Death

May 18.

8. Date of Birth

Dec. 17, 1922

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Dewitt Austin HARP, Jr. Medical lau 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min 85 Director 215-20-9813 Feb. Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Washington Hagerstown 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 11234 Scarlet Oak Drive items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Deceue... Armed Forces? 1 X Yes 2 □ No 1 Yes Give 1943 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates id Mental Hygiene. marked other than "natural", Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Janitor Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dewitt Austin Harp, Sr. Mary Catherine Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deena Harp - Daughter 11234 Scarlet Oak Drive, Hagerstown, MD. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 5/17/10 Hagerstown, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Minnich Funeral Home ames nou 415 E. Wilson Blvd. Hagerstown, Md. 23a. Par 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Esquentiary list somutions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atter Id be detached for u 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should peen 24a. Was an has autopsy certificate Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Tho Other: Certificate: To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural Accident 5 Pending 1 🗌 Yes Investigation Could not be npleted filled in by the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

9. Birthplace (State or Foreign Country) New York

White

10d. Inside City Limits 1 Yes 2 X No

Interval Between

Onset and Death

Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

12:40 AM

Year

OVO

Hageistan, MD 21740 Jaseem MD mad 31. Date filed (Month, Day, Year) State MAY 19 Registrar

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	Physici: /Medic		PAULINE	HE	NRIETTA	HO	SE			Month.	Day	Year 2010	11.55 PM			
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212	filed within Hygiene. ether than	Completed	7	y (0-12)	College (1-40) 5)+)		Housewife				Home				
nd		Be	17. Father's Name (First									Maiden Surname)				
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Ma	nd 2 sho Ith and 27 is ma trauma		19a. Informant's Name/ Edwin A. I						and Number or Ru ad Sharps				^			
ē,	ges 1 and 2: It of Health a If item 27 is or other trai		20a. Method of Dispositi	tion		20b. P		sition (Name of natory or other pla		Date Date	20c. Location - City or Town, State					
m 0			1 極 Burial 2 ☐ Cro 4 ☐ Donation 5 ☐		Removal from State (fy)	1	or Cen			24,2010	Tilghm	anton,	Maryland			
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of unera	Service Lice	nsee		- 1		nerally Horococheag	-		port.	MD 21795			
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Вох	ath ce	ian/l	23b. Was decedent preg		23c. If yes, outcome	2 🗀 Fetal	death 3 [Ectopic pregnanc	у			Date of delive Month	ery Day Year			
o	that the de	Physician/Medical	1 □ Yes 2 □ No 9 □ Unknown		4 ☐ Pregnant a 9 ☐ Unknown	t time of di	eath 5L	Other (specify) _								
υ,	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did	tobacco use co	ontribute to th	ne cause of death?			
ord.	w requires that s been signed t should be deta									1 🗆	Yes 2 □ No	3 ☐ Prob	pably 4 \ Unknown			
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<u> </u>		Be o	25. Was case referred to examiner?	o medical	Hospital:		ED/O +	t 2 DOA Oth	26. Place of Dea	,						
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ioi	Attending r death. ector; After by the funer	atio	2 🗖 Accident	Pending investigation		y, rear)	Injury	M 1 🗆	k? IYes 2□No							
Division of Vital Records,	or Atter de after de Directo	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not b determined		ury - At ho c. (Specify	me, farm, str	eet, factory, office		28f. Location City or To	(Street and Nu wn, State)	mber or Rura	al Route Number,			
_	To the Hospital or Attend within 24 hours after death. To the Funeral Director. / Completely filled in by the fi		(Check only 2	Certifying Pl Medical Exa	hysician: To the best miner: On the basis o	f examinat	wledge, deat	h occurred at the t	me, date and place	e, and due to the urred at the time	e cause(s) and	I manner as s	stated. o the cause(s)			
:	the lithin 2 the l	Medical	one) 29b. Signature and title		and manner sta	ated.		29c. Licens			29d. Date sig					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a per phys. G904 6/11/10 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 1550 PM Catherine Rebecca HEMP 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Hours Min. (Month, Day, 87 Director 217-18-8815 3 Maryland Usual Residence of Decedent show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 🗌 Yes 2 💢 No Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19912 Sheridan Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: White 3 Widowed 4 ☐ Divorced Specify. Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) Coilege (1-4 or 5+) Homemaker Her own home of Health and Mental Hygie f item 27 is marked other r other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fern Eugene Stottlemyer Annie Warrenfeltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mitzi Ann Hemp - Daughter 615 Westwood Street, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park | 5/21/10 Hagerstown, Maryland Dawn Mem. permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home <u>415 E. Wilson Blvd. Hagerstown, Maryland 21740</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Renal aillese disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertensive Cardiovascular Disease Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a sunsequence of: been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? σ, Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed' 1 Yes 2 No Yes 2 No Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ျ 1 Department 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred ieral Director: After filled in by the funer 1 Natural (Month, Day, Year) work? 1 Yes 2 No 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral C the Hospital Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D21457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. HAGERSTOWN. MD21742 11-7 ABOUL AKHI(WAHEED 12821-MUD gistrar's Signature State Registrar

30

69

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 24a per phys. G904 6/22/10 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/14/2010 Anna Mae Hall 6:30 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore City Arlington West Nursing Home 5. Social Security Number JKN If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min. 04/01/1936 Director 74 MD Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21215 USA 3939 Penhurst Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: 3 Widowed 4 Divorced Black Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bill Curtis Elsie Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1670 Anna Street, Shreveport, LA Anna Curtis - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetry, crematory or other place)
Ardent Cremation S 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from St Cremation Svc 5/17/10 Hanover, MD Signatury Funeral Service Licens Name and Address of Facility Snowden Funeral Home Washington St, Rockville, MD 20850 246 N. 23a. Part 1. Enter the disease or complicat shock, or heart failure. List only one pa ons that caused the death enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death use on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a conse Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a cor resulting in death) Last Physician/Medical Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Pregnant at time of death]Yes 2 ☐ No the Unknown 9 Unknown P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Waknown 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Ratural 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Prantianer To typust of my knowledge, death occurred at the time, date and place, and due to the 29b. Signature and title of pertific 10 29c. Lice 29d. Date signed (Month, Day, Year) 6 a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMONE HAZIZZA 1940 W. BALLIMONE WONETH MBACHEW Mi) 31. Date filed (Month, Day, Year) Registr & Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29c per DVR 8/9/10 G906 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2010 Month **Physician** HOWARD Mary Margaret 7.50 AM May 23, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Loyalton of Hagerstown Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 18,1922 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛛 F California 550-22-8128 88 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2本 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 2009 Rosebank Way 21742 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 XI If Yes, Give Ye ar or Dates: 2 🔀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🖾 No Specify δ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) nurse hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otto Carlson Sharp Mary ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si Department of Health an Important: If item 27 is n any Injury or other trau Vicki Al-Toukhi - daughter 2031 Wethersfield Court, Reston, Virginia 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 24 2010 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Licensee Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1 (Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ceronary disease Physician /Medical Due to (or as a consequence of): **Examiner** demention End 810 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) and Due to (or as a consequence of): been signed by the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy page 2 should be detached for Day Month Year in the past 12 months? 5 Other (specify) □Yes 2No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🗹 Nursing Home 5 🔲 Residence 6 🗀 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 12 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ 5/24/10 MD D66116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstowni MD, 21740 368 mu spreet 064-12 Dr. Andallet Ali,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eileen Frances Inglesby ^D2010 May 3:00 p 14, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3715 Gawayne Terrace Silver Spring Montgomery If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Jul. 25. Pennsylvania 1 M 2 X F Hours 87 **Director** 1922 167-18-8238 Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3715 Gawayne Terrace 20906 USA death v Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No ş 72 hours after Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Francis Kennedy Marie Gertrude Crosson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 shound Health and item 27 is n Eileen M. Inglesby-Houghton /Daughter 16 Crest Park Court Silver Spring, MD 20903 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Arlington National Cemetery, June 15, 2010 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service 22. Name and Address of Facility Francis J. Collins Funeral Home, 500 University Blyd., W., Silver um MD 20901 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Aspiration Pneumonia disease or condition Week Medical resulting in death) Due to (or as a consequence of) **Examiner** Alzheimers Disease 4 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and I-transit Exam Hospital or Attending Physician: The law requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Unknown g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been signal 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? certificate 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 XXResidence 6 Other (Specify) 1 🗌 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director; /
completed filled in by the f Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0000/43

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Year)

8 2010

Hubert J. Alpert, MD 6410 Rockledge Drive #401, Bethesda, MD 20817

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <u>Wayne Edward Jordan</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Young)
April 14 7. Age (In vrs. last hirthday) Funeral 1**X**] M 2 □ F Months Hours **Director** 1943 67 217-42-9355 Usual Residence of Decedent 28a-f show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Maryland Washington Boonsboro ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 7114 Sharpsburg Pike 21713 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ö þ 1 Never Married 2 X Married 1X☐ Yes 2☐ No If Yes, Give 1960–64 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 'natural", Specify: 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Mason National Park Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o Department of Health and Menta Important: If item 27 is marked any injury or other transcores. မ Walter Keller Jordan Margaret Armenta Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Jordan - Wife 7114 Sharpsburg Pike, Boonsboro, Md. 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 5/19/10 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, MD. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of sician and burial-transit that initiated events resulting in death) Last ng physician as the burial Physician/Medical 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown fo Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Addisons mease Records, Completed 24a. Was an autopsy performed? Yes 2 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a Certifier To the

Onset and Death month 23d. Date of delivery Day Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated No the 29b. Signature and title of certife 29c. License number D 44996 may 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24 Na11 MB 20311 Lappan, Rd Boonsboo MO 217/3 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2X No

Maryland

Black, White, etc.

White

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d per phys. G905 7/22/10 dk. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) aol(Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner cashinator COMMISE 7. Age (In yrs. last birthda) 9. Birthplace State or Foreign Country Maryland 8. Date of Birth (Month, Day, Year) July 11,1936 5. Social Security Number **Funeral** Min. 1 M 2 □ F Months Hours 579-48-2071 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items be notified at xry or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Washington Director Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19800 Tranquility Circle 21742 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ՃYes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: ģ Specify: white 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electrical power generator operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Schitzker Howard Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13713 Village Mill Dr., Maugansville, Md. 21767 David Jones - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 5/20/10 Hagerstown, Maryland Rest Haven Cemetery 4 Donation 5 Dother (Specify) MINNICH FUNERAL HOME 21. Signature of Funeral Service Licer 22. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Coronau disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Stel if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate ba executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide ACCERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated May 18, 2010 29c. License number 29b. Signature and title of certifie 18/10 D0066116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 368

32. Registrar's Signature

eeb

Year) Y 2

ndal 31. Date filed (Month, Day, Y Hagerstown

Please Type or Print in Black Indelible Ink Frsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death ounty of Death **Examiner** If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month Day Year) Months Days Hours Min 169-46-58 Yrs. Director ennsvlvani Usual Residence of Decedent 28a-f shov 10a. State injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD. Harford Jarrettsville 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 1574 W. Jarrettsville Read 21084 United States within 72 hours after death 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2-1 No Black, White, etc. ö þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", White 3 Divorced 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Farmer Farming Be Maryland be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Johnson Sr. W. Mary Karr and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Patricia A. (Wife) Johnson Jarrettsville Rd. Jarrettsville, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 4. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville Cem 2010 Jarrettsville. 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, Jarrettsville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): r Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and sthe burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 🗀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending s ar er death. Accident 1 🗌 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29d. Date signed (Month, H0062021 30. Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month egistrar's Sig State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/ Month May 14 5:10 A. Rachel Mae King Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington <u>Broadmore Assisted Living</u> <u>Hagerstown</u> 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 24 Hrs. Social Security Number **Funeral** 1 □ M 2 🔯 F Hours Country)
Virginia Months 81 Yrs Director 223-32-7567 08/19/1928 Usual Residence of Deced ral", or items 23a or 28a-f show Examiner must be notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Frederick MD Frederick 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21702 United States 410 Biggs Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or Baltimore, Maryland 21215-0036 nan "natural", 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the school system crossing guard 6 traumatic event, Be Department of Health and Mental Humbortant: If item 27 is madiany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Della M. Morris Lester Shifflett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code 3715 Jefferson Pike, P.O. Box 94, Jefferson MD 21755 Leonard T. King /son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resthaven Mem. Gardens 5/18/2010 Frederick, MD 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service License supulu kun 106 E. Church St., Frederick, MD 21701 MO1222 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CARCINOMA METASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ed by the a 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MALLITUS hTPRRTENSION 1 Yes 2 No 3 Probably 4 Unknown HYPERLIPIDEMIA HYPE THYREID ISM 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? DEMENTIA certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSITE & HUINE Hospital မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 injury 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aff
d in by the ful 2 Acciden
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D0018019 Talt MO 14 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASALT 340 mill ST. HALERSTOWNMD 21740 DATTA MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MA Y Physician/ 2010 1:05 AM Gussie Ellen Keyes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day Yea
Nov. 27, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🛣 F 1950 MaryTand **Director** 217-56-0206 59 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 424 N. Johnathan St. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 🗌 Yes . 2 🔀 No Specify: 3 Widowed 4 Divorced **Black** Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 th County Government Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Eleanor Snively Frank Sylvester Keyes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 139 19a. Informant's Name/Relationship (Type, Print) 55 Melbourne Court, Bunker Hill, WV 25413 C. Andre Kidrick 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery May 27,2010 Hagerstown, MD 21740 Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St. Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEGSE Physician/ Chron. C resulting in death) Medical Examiner Sancoido Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi chagni Due to (or as a consequence of): resulting in death) Last Physician/Medical Diabetes Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death g 🗌 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed this certificate 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 **J M** 1 Inpatient 2 ER/Outpatient 3 DOA မှ To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral director. 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accider 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARID m D 31. Date filed (Month, Day, Year) State MAY 24 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Karen Lynn Keener 2010 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13626 Broadfording Church Rd. Washington County Hagerstown 8. Date of Birth (Month, Day, Year)
April 21,1961

9. Birthplace (State or Foreign Country)
Pennsylvania If Under 1 Year | If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1 X M 2 □ F 215-84-5275 49 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Maryland Washington county Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13626 Broadfording Church Rd. 21740 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White δ Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other than any lnjury or other traumatic event, It sonce. Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Rager Kathleen Rosenbaum Rager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13626 Broadfording Church Rd. Hagerstown, MD 21740 Keith Keener-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 5-19-2010 | Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 Kaitlin Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** 2 man /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 2 Z No 1 □ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License numbe-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 12

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 18^{Day} Month 20ĬÖ 12:32 P M **Physician** May Jo Ann King /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County 19639 Spring Creek Rd. Hagerstown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F 214-24-1342 South Carolina July 20,1930 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninal routine on titled at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐Yes 2 No Director Maryland Washington County Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19639 Spring Creek Rd. 21742 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arbutus Parris Blackwell Dufay Blackwell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15902 River Bend Ct. Williamsport, MD 21795 Pamela A. Finster-daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-22-2010 | Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service I Eastern Blvd. North Hagerstown, 1331 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco dse contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗌 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performe 1 □Yes 2 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, 25. Was case referre examiner? medical Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner / Death 5 ☐ Pending investigation 1 tural 2 Accident 1 ☐ Yes 2 ☐ No death. Sempletely filled in by the within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and

State Registrar 31. Date filed (Month, Day, Year)

MAY 2 1

32. Registrar's Signature

Please Type or Printin Black Indelible to 14 Ensure Adl Sepies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2010 Year May 21, **Physician** 6:00 A M Russell B. Keener /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Ravenwood Assisted Living Hagerstown 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 2, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1 X M 2 □ F 217-10-2527 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Marieral Event or other traumatic event, If a Marieral Event in a must be must be any injury or other traumatic event, If a Marieral Event in a must be must be any injury or other traumatic event, If a Marieral Event in a must be marieral event. 1 XYes 2 □ No Director Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1183 Luther Dr. 21740 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White þ 3 X Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Company Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin B. Keener Lelia C. McCoy Keener 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lyn K. Totty-daughter 13137 Fountainhead Rd. Hagerstown, MD 21742 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-25-2010 | Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): aftending physician for use as the burial Physician/Medical for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Hinknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of After this funeral c 28b. Time of Injury ie Hospital or Attending Pl 24 hours after death. ie Funeral Director; After tl 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0055994 Name and address of person who completed cause of death (Item 23a) (Type, Print) HILLOMED OGH-Y HIGGEN BOTHAM, W. D 31. Date filed (Month, Day, Year) MAY 24 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5/22/2010 3. Time of Death Physician/ Inda 06:45 AM Kee Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSP.7. nwot Wa Hapers shing ton ash.r County If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Days Hours 12 Month, Pay Year) 55 Yrs Director 215-64-2466 Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🄀 No MD Washington Hancock 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8929 Slabtown Road 21750 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exm Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roy Sherwood Shoemaker Valeria R. Yonker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary L. Keefer, Jr./Son 8939 Slabtown Road Hancock, MD 21750 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 05/24/2010 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, MD Sinatule of Funeral Service Lice 22. Name and Address of Facility 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final 0 diac arrest Physician 9 Q disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner cen 0 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): has been signed by the attending physician and e 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical eted filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 XN0 1 X Inpatient 2 - ER/Outpatient 3 - DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending work' 1 Yes 2 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 10 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 0068976 22 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEVENE Hospital irum COUNTY Wa 31. Date filed (Month, Day, Year) Registrar's Signatu State JUN 03 Registrar DHMH 17 Rev 7/2009

BY

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 5 per FH G905 7/22/10 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last). 2. Date of Death 3. Time of Death Year **Physician** Month Ain 4010 /Medical Examiner 42 (If not institution give street an County of Death 4b. City, Town, or Location of Death 4c. 2 01 If Under 1 Year | If Under 24 Hrs. Birthplace State or Foreign
Country **Funeral** 6. Sex (In yrs Days Months Hours 1 M 2 D Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any folury or other traumatic event, the Medical Experience must be notified once. 1 Pres 2 No Completed by Funeral Director Street and Number 4101 10g. Citizen of What Country? 10f. Zip Code Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/9e condary (0-12) College (1-4or 5+) 17. Rather's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be ပ NOW 19a. Informant's Name/Fielationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disport 20a. Method of Disposition 20c. Location -City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation 21. Signature of Furgral Service License box 259 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line.

Immediate Cau e (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been siç , page 2 should b IDDM 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown HTN24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autonsy perform PVD 2 **X** No 1 ☐ Yes 2 🗆 No 1 □Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation r death. 1 ☐ Yes 2 🗆 No within 24 hours after death
To the Funeral Director: MIA 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062190 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. HIGH STREET, SUITE 314, ELKTON, MARYLAND 5 SHAHNAWAZ KHAN MD 111 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12 ay 201 0 ar Mary 17:16 M Gabriella Legradi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Days 1 M 2 XF Hours Min. June 10 Year 19<u>23</u> Hungary Director 86 577-56-1292 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 √ Yes 2 □ No MD Kensington Montgomery 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 20895 U.S.A. 10225 Frederick Ave. Apt 308 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11, Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 ₩Widowed 4 Divorced White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>Derma</u>tologist Dermatology 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Fischer Jozef Tarjan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 19a. Informant's Name/Relationship (Type, Print) <u>5705 Chapman Mill Drive Apt</u> 3301 Rockville, MD Elizabeth Keith/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₭ Burial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Memorial Pk | 5-17-2010 Olney, Maryland 4 Donation 5 Other (Specify) 22. Name and Addr Edward Sagel Funeral Direction, Inc. Signature of Funeral Service Licensee M01597 McGreen Melissa Greenhut 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Insattage Reath Immediate Cause (Final Sepsis Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Weeks Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Weeks Acute Renal Failure Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy as been signed by the atter in the past 12 months? Year Month Day 5 Other (specify) g 🗀 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' Yes 2 XNo 1 ☐ Yes 2X No Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 잍 4 Nursing Home 5 Residence 6 Other (Specify, s after deam.
al Director: After the in by the funers 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, noleted filled in by 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0069759 10. Name and address of person who completed cause of death (Iter Belay Woldegiordis Atnafu, MD iordis Atnafu, MD Shady Grove Adventist Hospital Rockville, MD 20850

Registrar

State

31. Date filed (Month, Day,

8

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Ruth NMN Lahnig 901C 0752 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 27 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 1 M 2 X I 81 Country) Germany Director 218-38-1135 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or lother traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 X Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 1115 Outer Drive U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Garment Factory Presser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Johann Fries Martha Eifler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette G. Yeakle/Daughter 190 Prospect Ave. State Line, PA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 5/18/2010 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 21742 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician. 0 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a conse quence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of) burial been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death g 🔲 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an After this certificate has page 2 performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Cther (Specify, 2 No ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury To the Hospira.

within 24 hours after death.

To the Funeral Director: After completed filled in by the fur 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier DC Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 shafrid 32. Degistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Esther Billmyer Lee 5:15 PM May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Williamsport
If Under 1 Year | If Under 24 Hrs. Homewood at Williamsport

5. Social Security Number 6. Sex Washington 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Months Days Hours 1071671918 Mary Land 224-10-8311 Director 91 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Williamsport Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21795 16505 Virginia Ave 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: White 3 X Widowed 4 Divorced Year or Dates or other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72.1 and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Public Health Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Franklin Eutsler Sr. Lou Virginia Mytinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Paul F. Lee / Son 1353 Bays Water Dr. High Point, NC 27265 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Edge Hill Cemetery 5/20/2010 Charles Town, WV 21. Signature of Euneral Service Licenses Gerald N. Minnich Funeral Home Potomac Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician ACCIOLL disease or condition resulting in death) Varado w Certon Medical Due to (or as a consequence of): Examiner Alini Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of). teno (dete Cen burial-transit 4 that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Id be detached for a I Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by I Mo Mila Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dement 24a Was an page 2 autopsy performed? certificate 2 🗌 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29c. License number 2 29d. Date signed (Month, Day, Year, att MD P0018014 18,2010

Registrar
DHMH 17 Rev 7/2009

State

VASAUT

aistrar's Signature

HACERSTOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Glenn Arthur Mast Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS Regional Medical Center Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. April Dazzar 1943 Pennsylvania 218-48-9145 Director 67 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21536 USA 1146 Springs Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black. White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Owner/Operator Appliance Repair 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Sara Eichorn Ernest Mast 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1146 Springs Rd., Grantsville, MD Edna E. Mast/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State May 17, 2010 Springs, PA 4 Donation 5 Other (Specify) Springs Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CEREBRAL Physician/ VASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DISEASE ORONARY Sequerifially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 🗌 No detached 1 ☐ res ∠ ☐ 9 ☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 Yes 2 No 3 Probably 4 Unknown VERTEBRO BASILAR VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifi CARDIOTHORACIC SURGEON

State Registrar 31. Date filed (Month, Day

2501 WYKWBROCK RUAD

CLEMBERIAND, MD. 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legib State of Maryland / Department of Health and Mental Hygiene	le.	^		weg	0	-
State of Maryland / Department of Health and Mental Hygiene	201	U	1	7	5	C
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£				not institution, give street and number) ton Manor Road						Town, or l and	ocation o	of Death	4c. County of De			f Death		
Funeral		5. Social Security I	Number	6. Sex		7. Age (I	In yrs. la	st birthday)	If Und	er 1 Year s Days	If Unde			-		9. Birt Foreig	hplace (State or	
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out Exami		Gene Wayne Max 4a. Facility Name (if not institution	SON on, give street and r	number)		41	. City, To	wn, or Lo	cation of D		-,, -		County of Dea	th
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Division of Vital Records, P.O. Box 68761 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t		(Ontook only	Physician: To the taminer:On the bas	est of my kn	owledge	e, death occurr	ed at the	time, date	e and place death occu	e, and due irred at the	to the cau	ise(s) ar and pla	nd manner as si ace, and due to	tated. the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bessie Mantzouris May 2010 5:36 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6001 Muncaster Mill Rd.-Casey House Rockville Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, une 26 1 □ M 2 🗷 F Days Min 577-24-0193 87 **Director** June 1922 Washington D.C Usual Residence of Decedent should be filed within 72 hours and word Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show a law and the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Md. Howard Highland 1 🗌 Yes 2 🗶 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6730 Mink Hollow Road 20777 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U. S. Government Accounting Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nicholas Mantzouris George Helen. Kalavritinos Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Deborah M. McKeever/Per. Rep. 413 Brighton Knolls Dr., Brinklow, Md. 20862 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Salem Cemetery 4 Dogation 5 Other (Specify) 5/20/10 Brookeville, 21. Signature of Funeral Service Ligensee 22 Name and Address of Facility
Muriel H. Barber Funeral Home -009 0. Box 5038, Laytonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ COPD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and I-transit Exami that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical attending pl IE FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Respiratory Failure has performed? Yes 2 No 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) 2 🔀 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 124 hours after death. E Funeral Director: Aft leted filled in by the fur 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Box 68760 P.O. Records, Division of Vital Hospital сотретер To the within 2 To the

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Nicole Christenson, C.N.P.

M-54000 (30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 7/2009

The design of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

6001 Muncaster Mill Rd.,

29c. License number

R 120698

May 18, 2010

20855

Md.

Rockville,

John	Thomas	McCutchan
		1- For S

	1- For State Registrar Certificate of Death Reg. No.	1735
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	Time of Death
Medical Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	1707 hrs
a chi	University Hospital Baltimore	
Funeral Director	Aug. 22. 1972 Count	alifornia
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City	Od. Inside City Limits
show a	Maryland Cecil Bonnuille	Yes 2 No
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country	?
ith the 23a or notific	1433 Carpenters Point Road 21903 U.S.A.	
er death with 1 , or items 23s r. must be not Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc.) 14. Race - American White, etc.	ı Indian, Black,
s after d	Specify: WI	hite
hours "natur Exam	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Induktion (Specify only highest grade completed) 16c. Kind of Business/Induktion (Specify only highest grade completed) 16d. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
5-0036 ed within 72 hour fygiene. other than "natt. the Medical Exar. Completed	Twelve Years HVAC Specialist Beltsville,	•
5-0 lied willed will Hygie I other I the M	17. Father's Name (First, Middle, Last) The area of Country Manager (First, Middle, Maiden Surname)	
21215-0036 total be filed within 7 d Mental Hygiene. s marked other than tic event, the Medica To Be Comple	Thomas C. McCutchan Helen Noreen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi	- 0-4-)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Jae M. Sly South Friendship Court, Colora, Maryla	
ore, as l and of Heal	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Cremation 3 Removal from State Removal from State Crematory or other place) 20b. Place of Disposition (Name of cemetery, Crematory or other place) 20c. Location - City or Tow West Cheste	vn, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite njury or other tr	A Donation 5 Other Specify: R.A. Ferris & Co., Inc. 04/21/10 Pennsylv	ańia
Balt permit. Depart Import	21. Jignature of Funeral Service Scensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766	.A.
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval
/Medical Examiner	Immediate Cause (Final disease a Multiple Injuries	Between Onset and Death
d	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions	
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	
red Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
760, icate be executed physician and the burial - transit	UNPENDED X AMENDED #1, as noted, per ME G904 6/7/10 TT	
'60, cate be execu physician am ne burial - tra		
687 ertifica ding pl e as the	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
). Box 687 the death certific by the attending p ched for use as th	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	
G. t. t. p. d. g. g. g. g.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	cause of death?
S, P puires ti na signe Id be d	1 Yes 2 No 3 Probably	
Records, P.(The law requires that freate has been signed page 2 should be det		sy findings available pletion of cause of
Division of Vital Records, tal or Attending Physician: The law requirer staffer death. al Director: After this certificate has been sited in by the functal director, page 2 should be rifification: To Be Completed	1 Yes 2 No 1 Yes	2 No
Vital hysician this certial director	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: Other: 4 Nursing Home 5 Residence 6 Other:	
ing Ph After t funeral	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred	
Division of ital or Attending Ital or Attending Irs after death. ral Director: Aft lled in by the funcertification:	2 Accident Investigation	
Division Division Attent ours after death neral Director: filled in by the	3 Suicide 6 Could not be determined (Specify) Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural For Town, State) 1500 Carpenter Point Road, Charlesto	oute Number, City
e Hospi 124 hou e Fune etely fi	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cal and manner stated. 29b. Signature and title of certifier 29c. License number. 29d. Date signed. (Mosth is	
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Manual Prince) 29d. Date signed (Month, Manual Prince) 29d. Date signed (Month, Manual Prince) 29d. Date signed (Month, Manual Prince)	Jay, Year)
C	30. Name and address of person who complete cause of death (Item 23a)	
δ	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	
DHMH 17 Rev 1/2001 OCME 2006	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND, PER COURT ORDER, G952 6-6-14 SM
State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#5penFH, 5/25/10, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 17,2010 Catherine Miller Miller R. 10:05a м Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Montgomery 4952 Sentinal Dr #306 Bethesda 7. Age (In yrs. last birthday) 82 yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y March 1 9. Birthplace (State or Foreign ar) 1927 **Funeral** 1 M 2 X F Greece Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD Montgomery Bethesda 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 20816 Funeral 4952 Sentinal Dr #306 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name *(First, Middle, Maiden Surname)* E**11y Iliopoulos** 17. Father's Name (First, Middle, Last, George Antoniadis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4952 Sentinal Dr #306, Bethesda, MD 20816 Robert H. Miller /Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 21,2010 Washington DC Rock Creek Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Son, INC 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Colon Cancer Physician/ disease or condition Years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1X Natural (Month, Day, Year) 5 \square Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 05/17/2010 29b. Signature and title of certifier 29c. License number D0033293 6 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Smith MD 5454 Wisconsin Ave. #1300 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year)

MAY 18 2010 3. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dα Month Physician/ P^{M} 2:42 Miller May Medical <u>George</u> 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 X M 2 □ F Min. (Month, Day, Year 02/22/192 Poland Months Days Hours **Director** 066-16-1698 88 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 X Yes 2 No Adelphi MD Prince George's 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò event, the Medical Examiner must be Funeral 23a 20783 USA 0513 Edgefield Dr. items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. rces? 2 D No 1943 re 1945 1 Never Married 2 X Married ò Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: 'natural", 3 Widowed 4 Divorced White Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Contracting Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ David Miller Sarah Berger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra <u>Estelle Miller / W</u>ife 10513 Edgefield Dr. Adelphi, MD 20783 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grdns: 05/18/2010 Falls Church, VA 22 Name and Address of Facility Edward Sagel Funeral Direction Inc. 21. Signature of Funeral Service Licensee Kurt Blake 10191 Rockville Pike Rockville, MD MO1477 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final coess ₽uysician/ STONA disease or condition resulting in death) **Medical** Due to (or as a consequence of): Dertension ≝xaminer Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) g Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical WAShington Haventist 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

DHMH 17 Rev 7/2009

Registrar

(Check

only one)

3

29b. Signature and title or certifier

INCENT

31. Date filed (Month, Day, Year)

9

parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAShing ton

Registrar's Signature

AMES

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7600 Carroll

Advents+

29d. Date signed (Month, Day, Year)

TAKOMA

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:20 PM Mar 2010 Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of L 4c. County of Death Town, or Location of Death Examiner 7731 Rock Jashina ourt 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Hours Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10h. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No WASHINGTON WILLIAMSPORT MARYLAN 10e. Street and Number 10g. Citizen of What Country? Funeral KOCK 731 IVER 217) S A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian was becedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates./ 9 71-73 Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 1 Yes 2 No Specify: WHITE Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MEDICINE PHYSICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, HUBBARD MEDOUGAL ELEANOR MARIE 19a. Informant's Name/Relationship (Type, Print) SPOUSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Annapolis BESTGATE MEMORIA4 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fineral Service Licensee m metogrape 22

M. M. DOUGAL SPOUSE 7 ROCK CT., WILLIAMSPORT, MD 21795 SCILLA MI MCDOUGAL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Scleroc Physiciani myotronhi 8 monta disease or condition Medical resulting in death) Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed ins certificate has been s director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Alesidence} \) 6 \(\text{Other} \) Other (Specify) ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 29c. License numbe 29d. Date signed (Month, Day, Year) CZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14+1 egistrar's Signatur 31. Date filed (Mo. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frances Machen L. Month 2010 :10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 Months Hours Min. 03/17/1932 Waynesboro, Director 213-42-1524 78 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 Springfield Lane 21795 US 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: white Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) owner music store permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William L. Machen Nellie L. Huff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Bragunier/friend Church St. Williamsport, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/21/2010 1 Burial 2 ACremation 3 Removal from State Cumberland Valley Crematorium 4 ☐ Donation 5 ☐ Other (Specify) Waynesboro, PA 21. Signature of Fune at Service License 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc 50 S. Broad St. Waynesboro, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 __ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy n the past 12 months Day Pregnant at time of death 2 No After this certificate has been signed by the funeral director, page 2 should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not esy e contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 N 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ပ 1 Yes 2 ER/Outpatient 3 DOA Inpatient 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral Natural Accident 5 Pendina 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Day 30 Physician/ CLARENCE F. MYER 12:25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death **Examiner** Burne altimore Washington Medical Center Anne Arunde Glen If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 D F 6 19 17 Pro 22 MARYEAND 87 215-44-3614 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director MD 28a-f ANNE ARUNDEL ARNOLD 1 ☐ Yes 2 🂢 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 979 FOREST DRIVE 21012 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1XXYes 2 \(\subseteq \text{No} \) Black, White, etc. 9 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) DEFENSE DEPARTMENT Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER (FEDERAL GOVERNMENT) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN C. MYERS MARGARET BECKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 979 FOREST DRIVE, ARNOLD, MD 21012 19a. Informant's Name/Relationship (Type, Print) DOLORES FOX (DAUGHTER) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 Removal from State HEDGES CHAPEL CEMETERY HEDGESVILLE, WV 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ neumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic obstructive pulmonary disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? coronary artry 24a. Was an autopsy performed' 2 No Yes 2 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: |၉ 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 within 24 hours To the Funeral

> State Registrar

DHMH 17 Rev 7/2009

(Check

MCC

31. Date filed (Month, Day, Year)

wace

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

301 Hospital Drive Glen Burne MD 21061

D00623

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul Michael Month May Noga 16 2010 av 11:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day,) 1 🗶 M 2 🗆 F Months Days Hours Min. New York 81 Director 089-22-0791 Jan. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d, Inside City Limits Director 1 Yes 2 X No MD Derwood Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20855 16924 Briardale Road United States 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
item 27 is marked other than "natural" and actions. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White Year or Dates. Korean Completed 3 Divorced 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the I B M Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stella Czarniewicz Michael Noga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia Noga / Wife С. 16924 Briardale Road, Derwood, MD 20855 Page 1 and 2 20b. Place of Disposition (Name of Me campton, or other place)
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ð 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State May 21, Alexandria, Virginia 4 Donation 5 Other (Specify) any inj Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 Gaithersburg, 10 East Deer Park Drive, urg, MD 20877 TRACY A. THUES 40/11 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Non Small Cell Lung Cancer disease or condition resulting in death) Months Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 🗌 No par the g Unknown 9 Unknown ed by t s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🕅 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1041

State Registrar Hoseph M.

з□

29b. Signature and title of certifier

(Check

32. Registrar's Signature

Haggerly

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph M. Hagerty, M.D., 9707 Medical Center Drive, Rockville, MD 20850

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D32407

29d. Date signed (Month. Day, Year)

May 16, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #10b,c,e & f per Fh G904 6/7/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 15: 50 M OREM PATRICIA MAY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a The Johns Hopkins Hospital Baltimore City Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 M 2 X F 60 Sept. 12,1949 Director Maryland 214-54-1154 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location **Bel Air** 10d Inside City Limits 10a. State 10b. Count 28a-f show Examiner must be notified at Harford 1 Yes 2X No Director -Cecil Maryland - Colora 10f. Zip-Code 21014 802 Old English Court Apt 2 B 10g. Citizen of What Country? 9 items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 o, 1 ☐ Yes 2X No White If Yes, Give Year or Dates: Specify þ 3 Widowed 4 X Divorced 'natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give Not use retired | Give 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked Mary Patricia Duggins မ John Louis Orem 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages
Department of Health and Important: If item 27 is ... injury or other tra 89 Wyatt Lane, Colora, MD 21917 John Orem/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 05-17-2010 me, P.A. 1 Burial 2 X Cremation 3 Removal from State Foard Funeral Home, 4 Donation 5 Other (Specify) Rising Sun, MD Signature of Funeral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 uchana 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY HYPERTENSION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a nonsequence of): The law requires that the death certificate be executed Due to (or as a consequence of) physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed has page 1 ☐ Yes 2 ☐ No Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Certification: 5 Pending investigation or Attending (Month, Day Year) 1 Yes 2 No 2 Accident after death. To the Funeral Director: A completely filled in by the 1 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral L Hospital 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number KES-000 MAY 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGGARWAL 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

back

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department / Department / Department / Department / Department / Departm	artment of Health and N rtificate of Death		ene g. No.	7362
	Physic	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	_Day Year	3. Time of Death
	/Medi	cal	Elbert Byron O'Keeffe 4a. Facility Name (If not institution, give street and number)	Ah City Town or Location of Doeth		4c. County of Death	6:05 P M
25	Exami	ner	12825 Cathedral Ave.	4b. City, Town, or Location of Death Hagerstown		Washington	County
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	if Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	O Birthn	lace (State or Foreign
	Director		505-07-0327 1 M 2 L F 96 Yrs.		Month, Day, Dec. 23	1913 Nebra	
	yland how		10a. State 10b. County 10c. City, Town or Loc			1	0d. Inside City Limits
	8a-f s	octo	Maryland Washington County Hagerston				1 □Yes 2 No
	with the a or 2	Funeral Director	10e. Street and Number 12825 Cathedral Ave.	10f. Zip Code 21742	10	g. Citizen of What Coun	try?
	ms 23	nera		Vas Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	U.S.A.	an Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at	by Fu	1 Never Married 2 Married 1 VYes 2 No	f Yes, specify Cuban, Mexican, Puerto I □Yes 2X No <i>Sp</i> ec <i>ify:</i>	Rican, etc.)	Black, White, e	etc.
15-("natu	letec	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ting 10	6b. Kind of Business/Inc	dustry
212	withir jiene. r than	Completed by		lian Employee		J. S. Army	
pu	e filed al Hyg l othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Surname)	
Maryland	S should be filed withi and Mental Hygiene. is marked other thar aumatic event, III. M	2	Elbert R. O'Keeffe		O'Keeffe		
Na Na	and 2 should ealth and Mer n 27 is marke ler traumatic			 Address (Street and Number or Rur Potomac St. 2nd 	-		,
re,	ss 1 and 2 of Health item 27 i		20a. Method of Disposition 20b. Place of Dispos			Oc. Location - City or To	
im	nit. Page partment ortant: If ortant: If injury or		4 Donation 5 Other (Specify) Smithsbur	g Crematory 5-17-		mithsburg,	Maryland
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licensee 22	Name and Address of Facility Dou	ıglas A.	Fiery Funer	cal Home
	402.00		23a. Part1. Enter the disease, or complications that caused the death. Do not enter	B31 Eastern Blvd.	North Ha	gerstown, N	D 21742 Approximate
Jan.	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.	2VCTVE LVN	19/1/50	JSE Y	Interval Between Onset and Death
1	Examiner		Due to (or as a consequence of):	EMA	/	4	IFACS
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			l	9.471
	execution and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		_		
68760,	tificate be executed g physician and as the burial-transit	edical E	Cd				
		Medi	IF FEMALE:			-	
Box	leath cert attending for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delive	ery Day Year
0	at the de I by the stached	ysic	1 ☐ Yes 2 ☐ Wo 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		58-5	,
s, P.	The law requires that the death certate has been signed by the attendir bage 2 should be detached for use	by Pi	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did toba	icco use coptfibute to th	e cause of death?
ord	w require s been si should b		170/10/11/01/01/01/N		1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
Vital Records,	has b	Completed			24a. Was an autopsy performe	prior to cor	psy findings available npletion of cause of
		e Co	25. Was case referred by medical	00 Pl	1 □ Yes 2	1 □Yes	2 No
Ţ	di si	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	045	h <i>(Check only one)</i> ome 5 DResiden	ce 6 ☐ Other (Specif)	v)
			27. Manny of Death 1 Phatural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how		·/.
Division	I or Attending after death. Director: Afte I in by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre	M 1 Tyes 2 No	28f Location /Stro	at and Number or Dure	I Paula Number
Σį	al or as after al Direction by	Certification:	4 Homicide determined building, etc. (Specify)	ot, lactory, office	City or Town,	et and Number or Rura State)	noute Number,
	To the Hospital or Atten, within 24 hours after deat in the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Medical Examiner: On the best of my knowledge, death and manner stated.				
	To the within 2 To The comple	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, i	Day, Year)
	YP		とうりいの行いのころ	100022043		5/17/2	010
	2941		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Finit RD LTAGE	RSTUW	V ms	21742
	Sta Registr	te ar	31. Date filed (Magrin Day, Year) 2010 32. legistrar's Signature	~~ 4		,	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2010 May 10:25 a^M VIRGINIA FLORENCE POLING 18 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dennett Rd. Manor Nursing Home 0akland Garrett If Under 1 Year 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 1 □ M 2 🔀 F 24, 1922 Director 218 16 3910 87 WV Dec. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show nnt: If item 27 Is marked other than "natural", or items 23a or 28a-f show nnt or other traumatic event, the Medical Examinar must be notified at any or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County X☐Yes 2☐No Funeral Director MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1113 Mary Drive 21550 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify ģ Specify. 3X Widowed 4 ☐ Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Cogley Mamie Nine ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward R. Poling, Son 127 Radnor St., Harrisburg, PA 17110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2X ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 05/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD Name and Address of Facility
David A. Burdock Funeral Home, P.A.
Oakland, MD 21550 21. Signature of Funeral Service Licensee Katherine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arterios /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to manediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person 31. Date State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Martha Padgette Peters 1900 2010 р May 15, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 👿 F Months Davs Hours Min (Month, Day, 91 Director 212-68-7321 TIN Jan 8, 1919 Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 123 Southwood Avenue 20901 USA ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 John M Champeno Clara Cochran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred A Peters /Husband 123 Southwood Avenue, Silver Spring, MD 20901 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o cemetery, crematory or other place)
Metropolitan Crematory 1 Burial 2 XI Cremation 3 Removal from State May 18, 2010 Alexandria, VA 4 Donglion 5 Other (Specify) 21. Signatur f Funeral Service Lice 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician Malignant Hypertension disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Intracranial Bleed Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Spinal Stenosis the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown detached i signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 K No မ 1 X Inpatient 2 ER/Outpatient 3 DOA Certificate: 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 1 XNatural 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

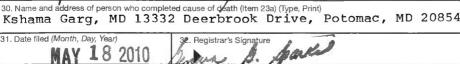
completed filled in by the funeral director, within 2 To the I

> 31. Date filed (Month, Day, Year) State 18 Registrar

(Check

only one)

29b. Signature and title of certifier



Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

May 17, 2010

29c. License number

D60826

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Terrisita Boone Porter May 6 2010 5:00 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House-Montgomery Hospice Derwood Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Hours Min. Days May 5, 1957 North Carolina Director 242-15-1684 53 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Boyds Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18411 Blue Moon Court 20841 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married þ Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes. Give Hygiene. 3 Widowed 4 Divorced Completed Year or Dates **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife and Mental Hygie Is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ရ Maggie Hardy Phillip Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Kevin R. Porter/Husband 18411 Blue Moon Court, Boyds, Maryland 20841 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. 5/17/2010 Alexandria, Virginia Signal are of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Metastatic Hepatobiliary Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 5 Other (specify) Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 No Yes 2 X No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital 2 🗓 No 1 🗌 Yes ဂ္ Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pendina ours after death.

neral Director: Af
filled in by the fu 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0070208 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eliezer Soto, M.D.,6001 Muncaster Mill Road, Derwood, Maryland 20855 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Eleanor Rozsics 13 2010 May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Center Montgomery Village Montgomery Montgomery Village Health Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F 06/16/1922 New York 87 156-05-2189 Usual Residence of Decedent 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 X No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19415 Brassie Place 20886 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Administrative Assistant</u> Government

Completed by 17. Father's Name (First, Middle, Last)

"natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Funeral

Director

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 the is been signed by the should be detached certificate has b irector, page 2 sl within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Ď	17. Father's Name (First, Middle, Last)			18. Mc	other's Name (First, Middle, M	aiden Surname)			
ပ	Lester E. O'Connor			V	iola M	adden				
	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address	(Street and Num	nber or Rural F	Route Number, (City or Town, State, Zi	ip Code)	7	
	Cheryl Shapiro (Daughter)	1941	5 Bras	ssie Pla	ce Mon	tgomery	Village,	MD. 2	20886	
	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	b. Place of Dis	position (Nar	ne of	May 1	te 2	20c. Location - City or	r Town, Sta	te	
	4 Donation 5 Other (Specify)	ete of Cemeter	Heaver V	i , , , , ,	2010	°	Silver Spr	ing,	Marylan	
	21. Signature of Funeral Service Licensee		22. Name an	d Address of Fac	cility DeV		ral Home			
	Cuetus E. Du		10 Eas	st Deer	Park D	rive Ga	ithersburg	rg, MD. 20877		
	23a. Part 1. Enter the disease, or complications the caused the dishock, or heart failure. List only one cause of each line.	eath. Do not e	nter the mod	e of dying, such a	as cardiac or I	respiratory arres	st,	Approx	rimate I Between	
	Immediate Cause (Final disease or condition Coronary A				and Death					
	resulting in death) a. Due to (or as a const		DIOCUL	,,,						
_	Sequentially list conditions, b. Hypertensi	Lon								
ine	if any jeaging to immediate . Due to for as a consi	equence or).					E P3			
хап	cause. Enter Underlying Cause (Disease or iinjury that initiated events c									
<u>ш</u>	resulting in death) Last Due to (or as a const	equence of):								
ğ	d									
₩e	IF FEMALE:									
ä	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 23c. If yes, outcome of pregnant in the past 12 months? 4 Pregnant at time of the past 12 months?	etal death 3	Ectopic p	oregnancy			23d. Date of de Month	livery Day	Year	
Completed by Physician/Medical Examiner	1 Yes 2 No 4 Pregnant at time of 9 Unknown	of death 5	Other (sp	ecify)			MOITH	Day	real	
占	Part II. Other significant conditions contributing to death but not	resulting in the	underlying o	cause given in Pa	ırt I.	23e. Did toba	acco use contribute to	the cause	of death?	
ο Ο						1 ☐ Yes	s 2 XINo 3 □ F	Probably 4	I I Unknown	
ete						24a. Was an				
п				autopsy	prior to	completion	of cause of			
	25. Was case referred to medical					1 Yes 2 No 1 Yes 2 No				
o Be	examiner?			26. Place of Do						
-	1 ☐ Yes 2 X No 1 ☐ Inpatient 2 27. Manner of Death 28a. Date of injury	☐ ER/Outpati 28b. Time		8c. Injury at			nce 6 Other (Spec	cify)		
Certificate:	1 XNatural 5 Pending (Month, Day, Year) 2 Accident Investigation			work?		a. Describe how	v injury occurred			
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							eet and Number or Ru State)	ral Route N	lumber,	
= '	C				- 1				i	

1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

May 14, 2010

29c. License number

D41162

Registrar

State

29a. Certifier

(Check only one)

29b. Signature and title of certified

Vinu Ganti, MD

MAY

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19529 Doctors Drive, Germantown, MD 20874

			Please	Type or Pri					-		_	
		For State Registrar		State of Ma	aryland /		tificate of		Mental Hy	/giene Reg. No.	211111	17367
Physici		1. Decedent's Nam	e (First, Middle, L Velma	ast) Irene Roy	er				2. Date of Do	eath	2010	3. Time of Death
/Medic Examin		4a. Facility Name (/	If not institution, g	ive street and number)			4b. City, Town, o	r Location of Dea	4.1	40.	Sounty of Deat	h,
Funeral		5. Social Security N		Sex 7. Ag	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bi	ay, Year)	Co	hplace (State or Foreign
Director		578-12-1 Usual Residence of	Decedent		95		ation		Sep 2	4, 1	914	Alabama 10d. Inside City Limits
Maryla a-f shov ified at	ctor	10a. State MD	10b. County Balt	imore		tonsv						1 ☐ Yes 2 X No
with the a or 28s	Director	10e. Street and Nu					10f. Zip Code	222		10g. Citi	izen of What Co	ountry?
death ms 23	Funeral	/U9 Ma 11. Marital Status	ilden Cho	ice Lane	Ever in U.S.	13. V	Vas Decedent of F Yes, specify Cub	.228 Hispanic Origin? (Specify Yes or N	0-	USA 14. Race - Ame	
is 1 and 2 should be flied within 72 hours after death with the Maryland is 1 and 2 should be flied within 72 hours after death with the Maryland female and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Marr 3 🏿 Widowed	ried 2 Married 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			Yes, specify Cub	an, Mexican, Pue Specify:	rto Hican, etc.)		Black, Whit Specify:	e, etc. White
72 ho "natur	eted	(Spec	15. Decedent's cify only highest g	Education trade completed)	1	(Give I	ent's Usual Occup kind of work done	during most of we	orking	16b. Ki	ind of Business	Industry
within jene.	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	5+)		oo not use retire okkeeper	a)		F.I	L. Watk:	ins
tal Hyg d other	Be C	17. Father's Name		st)			<u>,</u>	_	me (First, Middle	e, Maiden		
should be and Mental in marked o	ဥ	Char1		(Type Print)	1 4	19b Mailin	g Address (Street	Dora Dora	A. Boy		or Town State	Zin Code)
es 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 Is marked other than ir other traumatic event, the Mental Hygiene.			Royer (sc				Rainbow D				ton, TX	77399
		20a. Method of Dis	position	☐Removal from State	ceme	etery, cren	sition (Name of natory or other pla	· : Ana	Date il 20	20c. Lo	ocation - City or	Town, State
# 문원들		4 ☐ Donation 21. Signature of Fu	5 Other (Spec		ft.		oln Cem. Name and Addre	20	010		entwood	
Depariment of the concession o		1		ary J. Gof	f		3125 Sout	1	ryland B	lvd.	ome Cal Owings	lvert, PA s, MD 20736
Physician		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List on (Final	mplications that caused y one cause on each li	d the death. I	CO not ente	er the mode of dyin	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
/Medical Examiner			- 1	Due to (or as	a consequen	ce of):						
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tal or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	4 Zoe. Flace of [1]	ury - At home tc. <i>(Specify)</i>	, farm, stre	eet, factory, office		28f. Location City or To	(Street ar own, State	nd Number or R e)	ural Route Number,
To the Hospital or Attending Physician: The lywithin 24 hours after deafh. To the Funeral Director After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)		Physician: To the best aminer: On the basis of and manner st	of examination							
To t To t	×	29b. Signature and	d title of certifier	Stac	MD.)	29c. Licens	se number	9	29d. Da	ate signed (Mon	th, Day, Year)
JEWIO		30. Name and add	ress of person	o completed cause of		Ba) (Type,	Print)	n Cho	1.01	1	2 11.	e MD 21228
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Registrar DHMH 17 Rev 1/2001

den 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dennis Kevin Rosser Month 13, 2010^{ear} 12:19pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c, County of Death Prince Georges Hospital Center Cheverly Prince Georges Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 217-72-4773 Months Sept. 12, 1 😿 M 2 🗆 F Hours Director 50 Yrs. 1959 Washington DC Usual Residence of Decedent 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 275 is marked other than "natural", or items 23a or 28a-f sho approximant; if item 275 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Pleasant M D Prince Georges Seat 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1005 Glen Funeral Willow Drive 20743 apt.#14 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1₺ Never Married 2 ☐ Married Black, White, etc Baltimore, Maryland 21215-0036 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working National League of College (1-4 or 5+) life. DO NOT use retired) Elementary/Seconday (0-12) Editor Cities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Florence E. Towles John R. Rosser, Jr. 19a. Informant's Name/Relationship (Type, Print)

John R. Rosser, Jr. / father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Booker Drive, Capitol Hights, Maryland 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/18/2010 Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner nce of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No the Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Unknown certificate has been si rector, page 2 should I 1 Yes 2 No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 🗆 No Yes No No : After this certification of the funeral director, p 25. Was case referred medical examiner? æ 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 Ø Other: မူ ER/Outpatient 3 DOA Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manuer of Death Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 ☐ Yes 2 ☐ No neral Director: A ccident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier and address empleted cause of death (Item 23a) (Type, Print) Registrar's Signature State 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 445 KATHY A. RILEY 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-Regional Medical Center umberlang Allegany If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F (Month, Day, Ye 3-12-19 Months Days Hours MARYLAND 59 219-56-9454 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County filed within 72 hours after death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No CRESAPTOWN MD ALLEGANY 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21502 12830 McKAY AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Never Married 2 Married "natural", or þ 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates WHITE Specify 3 Widowed 4 □ Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CLERICAL WORK CREDIT BUREAU Be Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ BETTY WILT BEACHY PAUL HAMILTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12830 McKAY AVENUE CRESAPTOWN, MD 21502 GWENDOLYN SNYDER DAUGHTER Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 5-30-2010 CUMBERLAND, MD CUMBERLAND CREMATORY : 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility FROSTBURG, MD 21532 Man 60 W. MAIN MUUS47. 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between EUROEN DOCRINE CARCINOMA Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records. should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform has page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗷 No 1 \square Yes ည ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 24 hours after death.

Funeral Director: After injury 1 Natural 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. only one 29b. Signature and title of certifie 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

JUN 03

aamar Zaman, MD 12502 Willowbrook Road Cumberland, Maryland 21502 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2010 Year MAY 17 12:15PM WILLIAM LIGHT SCHAEFFER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WILSON HEALTH CARE CENTER GAITHERSBURG If Under 1 Year | If Under 24 Hrs. 3irthpia. Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/15/1918 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 □ F Months Days Hours 92 Director 219-34-8215 Usual Residence of Decedent the Maryland r 28a-f show rediffed at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD MONTGOMERY POOLESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ral", or items 23a or Examiner must be r 20837 14015 MONTEVIDEO ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⑤ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Completed other than "natur 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARMER AGRICULTURE 12 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM LIGHT SCHAEFFER, SR. EDITH CLUGSTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD SCHAEFFER / SON 14015 MONTEVIDEO RD., POOLESVILLE, MD 20837 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MONOCACY CEMETERY 05/24/2010 BEALLSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 20838 Approximate
Interval Between
Onset and Death
One mouth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cau Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) this certificate has been signed by the all director, page 2 should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ tension Ostes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Prostate Ca 2 LINo 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Many er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MRobert

14. ROBERT

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a

Year)

BIRSCHBACH, No ar) 32. Registrar's Signature

(Type, Print)

04115

201 RUSSEL

17,2010

UZWU2

10-03721 Steven Blaine Scott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	-1.0
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	173
Certificate of Death	

		1- For State Registrar	Certificat	te of Deat	h		R	eg. No.		
Physici	ań/	Decedent's Name (First, Middle,Last)					2. Date of Dea Month	Day Y	'ear	3. Time of Death
Medical Exam	iner	Steven Blaine Scott		10.00	.		May 15, 2	2010	hu of Dooth	0057 hrs
		4a. Facility Name (if not institution, give street and number) 1800 Blk Principio Furnace Road		4b. City, Perry		Location of E	Death	Cecil	ty of Death	
Funeral			e (In yrs. last birthd		er 1 Yea	ır İf Under 2	24Hrs. 8. Date of Bi	rth(MM/DD/YY	YYY 9. Birt	hplace (State or
Director		226-27-4837 1XXM 2 F	27	Yrs. Month	_		Min	/1982	Foreig	Portsmouth IntryVirginia
		Usual Residence of Decedent		113.	_1	11	00,2,	71702		,,, = 8
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Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip	Code		1	0g. Citizen of	What Cour	ntry?
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215-0036 be filed within 72 hours after death with the Maryland mai Hygiene. reked otcher than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?					? (Specify Yes or No uerto Rican, etc.)		ce - Ameri nite, etc.	can Indian, Black,
er dear or it	Ē	1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	X No	1 Yes 2	No.	specify:		Specify	v: TTL	
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5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5	du	ring most of wo	rking life	. DO NOT us	e retired)			
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5-00 iled wit Hygien I other		17. Father's Name (First, Middle, Last)					Name (First, Middle,			
MD 21215-0036 d 2 should be filed within 'f ith and Mental Hygiene. n 27 is marked other than numatic event, the Medica	o Be	Steve Blaine Forrester 19a. Informant's Name/Relationship (Type, Print)	I tob 1	Mailing Address	400		leen Marie			Zin Codo)
Shoul and N	⊬	, , , , , , , , , , , , , , , , , , , ,			•		orth East			
E 60 E 50		Kathleen M. Gerres / Mother	20b. Place of D	Disposition (Nar	ne of ce	metery,	Date	20c. Locatio		
Baltimore, MD Z permit. Pages 1 and 2 shou Department of Health and Minportant: If item 27 is in injury or other traumatic		1 XX Burial 2 Cremation 3 Removal from Sta	North E Methodi	or other place; ast_Uni	ted	_ I	May 20,	Nomeh	Foot	Monuland
Baltimo permit. Page Department of Important: injury or oth	1.3	4 Donation 5 Other Specify: 21 Igna or 2 uneral S i Licensee	Methodi				2010 Crouch Fui			, Maryland
Per Dep Time	. /	United 1 car								ry1and21901
Physician		a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.								Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Multiple Injuries								Death
LAUIIIIICI		or condition resulting in death) Due to (or as a conse	quence of):							
	ᡖ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	equence of):							
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x 687 h certific tending p		23b. Was decedent pregnant in the past 12 months?	2	Fetal death	3	Ectopic pr	regnancy	Month	D	ay Year
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D. B tribe de by the ached fe	P.	Part II. Other significant conditions contributing to death	but not resulting in	n the underlying	cause (given in Part I	. 23e, Did t	obacco use cor	ntribute to	the cause of death?
Division of Vital Records, P.O tal or Attending Physician: The law requires that it is after death. In Intercept. After this certificate has been signed be led in by the funeral director, page 2 should be detaed	ģ						1Ye	s 2 🗸 No	3 Prob	ably 4 Unknown
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ian: The certificate certificate		25. Was case referred to medical			26.Place	of Death (Ch	neck only one)	2140	1 🗸 10	3 2 10
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ision Attendi or death.	Certification:	1 Natural 5 Pending FOUND: May 15, 2010			1 \ \	Yes 2 ✓ No	o Dilver auto	nixed Object	COMSIO	
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Divis	Se	4 Homicide determined (Specify) Loc					1800 Blk Pri			
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as 1	ical	Check only one) 2 Medical Examiner: On the basis of example 1	/ knowledge, death nination and/or inve	occurred at the estigation, in my	time, da opinion	ate and place i, death occur	, and due to the cause red at the time, date	se(s) and mann and place, and	ner as state i due to the	ed. e cause(s)
To t To t Com	Medical	and manner stated 29b. Signature and title of certifier				e number				oth, Day, Year)
		Mana - De Marie			O.C.I	M.E.		May 15, 2	2010	
10		30. Name and address of person who completed cause of d	eath (Item 23a)		-			L		
10		Margarita Korell MD. Assistant Medical		11 Penn Str	eet, B	altimore, M	MD 21201			
s	tate	31. Date filed (Month, Day, Year) 32. Registra	's Signature	Kal						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ann Scot Month Year 0443 Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University Medical Maylad Cente Baltimore Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country all timore Mary land 8. Date of Birth 1 🗆 M 2 🕱 F Months Days Hours Min 07/31/1983 Director 220-04-1473 Usual Residence of Decedent shov ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes 2X No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Merion Circle 21901 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after Yes 2 X No 1 Yes 2 X No Specify: "natural", If Yes, Give 3 Widowed 4 Divorced White Specify. Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Residential Care other traumatic event, Be Department of Health and Mental H Important If item 27 is marked oth any injury or other trees. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Robert R. Dennison, Kimberly Mae Harris 19a. Informant's Name/Relationship (Type, Print)
Parents 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert and Kimberly Dennison
20a. Method of Disposition 2301 Manor Circle, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of 20c. Location - City or Town, State North East United Methodist Cemetery May 20. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 North East, Maryland 21. Signs reral Service Licenson 22. Name and Address of Facility Crouch Funeral Home South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure V. Ist only one cause on each line. Approximate Interval Between Onset and Death List only one cause on each line. Immediate Cause (Final Physician/ Cardiopulmonar disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Acidosis minutes Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) 40015 resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia HOUSS Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year 9 Unknown 9 Unknown Division of Vital Records, P.O. þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? rmed? 2 D No 1 Yes 2 No __ Yes 25. Was case referred to medical completed filled in by the funeral director. Be 26. Place of Death (Check only one) examiner? 1 Yes Hospital: မ 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at passenger of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 0049 Vehicle Acciden 115 2010 1 Yes 2 No Motor Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Street terryville Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔲 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifie 29d. Date signed (Month, Day, Year) MD 2010 255612 5/15/

Registrar

State

31. Date filed (Month, Day,

Year

22

Baltimore

21201

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death hysician Day Mary Jane Sparks 20โป๊ May 15. 9:45 p M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Care Center Elkton Cecil If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 28. 1942 Washington, DC Funeral 9. Birthplace (State or Foreign 577-56-8389 1□M 2**X**F **Director** 67 Yrs. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Exprired rust be notified at once. 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Cecil Port Deposit 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Misty Lane 21904 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🛣 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Agilent Technologies Elementary/Secondary (0-12)
Twelve Years College (1-4or 5+) Credit Analyst Wilmington, Delaware 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John M. Poole ပ Mary Jane Bethel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy T. Sparks (Husband) 6 Misty Lane, Port Deposit, Maryland 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West_Chester. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State R.A.Ferris & Co..Inc. 4 ☐ Donation 5 ☐ Other (Specify) 05/17/10 Pennsylvania 21. Sign ture of Funeral Service Licenses ^{22. Name and Address of Facility}
Lee A. Patterson & Son Funeral Home, P
Perryville, Maryland 21903-0766 Thomas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final " 'vsician meumonia disease or condition resulting in death) Lowerdung èdical Due to (or as a consequence of): Examiner Raheimor's Egpe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be a control of the conditions in the Examine The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of). Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) ed by the a detached for 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Completed page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Division of Vital 2 No 1 □Yes 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title certifier 29d. Date signed (Month, Day, Year) 5.17.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S. SACHDEV MD 126 A. E. Hud 126A, E 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2<u>010</u> Physician/ Month Mau 2:00a M Joseph Sutton Snead 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Nursing Home Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Months Days Hours Min. 577-18-2889 94 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🗓 No Silver Spring Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 U.S.A. 14905 Pennfield Circle 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Armed Forces?
1 X Yes 2 \(\subseteq \text{No } 1944-\) Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Caucasian Completed 3 X Widowed 4 Divorced 1945 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government of 1 and 2 should be filed within of Health and Mental Hygiens of them 27 is marked other the rother traumatic event, the Federal Agent/Revenue Agent Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဨ Saylor T. Snead Margaret Sutton 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Donovan Volpe-Daughter 14905 Pennfield Circle, Silver Spring, Maryland20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of once. ₽ cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 05/14/2010 | Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition SYSTEMIC SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONA ASPIRATION Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-trans attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached for g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed? Yes 2 X N After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 🗌 Yes 2 📈 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation hours after death Accident the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital within 24 hours a To the Funeral I Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

18

+1

38

3717

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D-17874

COTTAGE CITY

5-10-2010

MD 20722

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	0270					ney's					
	20200	_	23a. Part 1. Enter the disease, or complic	cc0278					NW		sning	ton		
١.			shock, or heart failure. List only one Immediate Cause (Final	cause on each line.				ardiac or	respiratory a	ireat,			Approximate Interval Bety Onset and D	ween
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B	the de	hys	g Unknown	9 Unknown										
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Division of Vital Records,	s after al Director		The months of the state of the	building, etc. (Specify)					City or Tov	vn, Stat	re)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physici (Check 2 Medical Examine)	an: To the best of my knowledge, d	eath occured at t	the time,	date and pla	ace, and	due to the ca	ause(s) a	and manner	as stated	I. se(s) and mar	nner stated
	the the the B	Me	only one) 3 L Certifying Nurse F	Practioner: To the best of my knowle	edge, death occur	red at the	time, date a	and place	e, and due to th	e cause	(s) and manr	ner as sta	ted.	
	F.≧ 6 8 €. ⊟		29b. Signature and title of certifier	-Ch, MD		License				29d. D	ate signed (20	ay, rear)	
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			30. Name and address of person who com		, ,	– اتد –	~~~±	α 1	on Da		11	v C-		910 MD
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Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SYED SHAMIM A. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYLAND MEDICAL CENTER BALTIMORE LTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔛 F Months Hours 59-969 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince GEORGES 1 Yes 2 No Greenbell 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20110 9342 EDMONSTON 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: ASIAN 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT, use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 'Kestorant Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATEINDUSTRY OTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SHAMIM ABU NOSAR M SHAMIN KASHIDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9342 EDMONSTON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemeter, crematory or other place)
Maryland National May 7,'10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel MD 21. Signature of Fysical Service Licensee 22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Avenue, N. W. Wash. DC20011 cc0278 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. oatitis disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (6r as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Yes 2 W 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 ☑ No မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 Natural 5 Pending 2 Accident
3 Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practiciper to the cest of my knowledge death oncurred at the time. Jets and place and place and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GREENE 57. MD 21201 SHAKTI NAYAR 22 BALTIMORE

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Ap^{Moft} $1 26^{\text{Day}}$ 201^{Year} 7:35 PM Joseph Sellman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Prince Georges heverl If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Wash. DC 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8 Date of Birth Funeral Months Days 1 M 2 □ F Hours Min 79 Yrs. Marchay, 1eg, Director 577-42-1114 Usual Residence of Decedent show 10c. City, Town or Location e 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show for other traumatic event, the Medical Examiner must be notified as 10a. State 10b County 10d. Inside City Limits Director Bladensburg Prince Georges 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20710 5999 Emerson Street 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 ★ Widowed 4 Divorced Year or Dates Black 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Food Service College (1-4 or 5+) Elementary/Seconday (0-12) Private Industry Chef 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ۵ Minnie Brown Thomas Reginald Sellman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Kelley/Granddaughter Department of Health Important: If item 27 any injury or other to 211 Rolling Hill Ct. Stafford, VA 22554 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) May 6, 10 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Olivet Mt. 22. Name and Address of Facility Latney's Funeral Home 21. Signature of Funeral Service Licensee cc0278 DC NW. Washington, 3831 Georgia Ave., 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Artic Encephalopathy Medical resulting in death) Due to (or as a consequence of Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Gasterointestinal Bleeding Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 2 No 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown been a 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2 r performe Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner' 2 🖪 No Hospital Other: ᅙ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at nours after death. neral Director: After the filled in by the funeral 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending injury 1 X Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral I Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical-Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) 4/26/2010 00K3703 son who completed cause of death (Item 23a) (Type, Print) Cheverly Md. 20785

State

Registrar

Tsion Berlane 3001

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Hospital Dr.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar		Ce	ertificate of	Death		. No 1	1/0/		
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호	Maryland Wash	ington	На	gerstown				1 □ Yes 2 🖔		
/ Funeral Director	10e. Street and Number	11150011	1.00	10f. Zip Code		100	g. Citizen of What	Country?		
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once	21. Signature ef Funeral Service	icensee "		22. Name and Addre	11.	innich Fu				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 20/0 Physician/ Month Saville Laura Lynn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 Months Days Hours Min. Aug 5, 1956 Virginia 219-66-1634 53 Director Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 ☐ Yes 2 X No Keedysville Maryland Washington 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 21756 5222 Mount Briar Road U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ð filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Window Clerk U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Baker Canoles Leona Loretta Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5222 Mount Briar Road Keedysville, MD 21756 Steven L. Saville, Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/19/2010 | Hagerstown, Maryland Cedar Lawn Mem. Pk. 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see in each line. Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or compli-shock, or heart failure. List only one Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-trans and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) been signed by the atte in the past 12 months? Year Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performe mphomou menina certificate 1 Yes 2 No 25. Was case referred to me une or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes Certificate: To 1 Dopatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month. istrar's Signature State 2010

Registrar

	-	State Registrar			Cer	tificate of l	Death			Reg. No	- U I	U	1/0	U
Physicia	n .	1. Decedent's Name (First, Middle,	· ·	COUNED	7				2. Date of Dea		ay Y	'ear	3. Time of [Death
Physicia /Medica		Kic	hard Leroy	SOUDERS	5				May 14		10		11001	М
Examine	er	4a. Facility Name (If not institution,	-			4b. City, Town, or		of Death			County of		n	
		17607 Woodlawn			11 1 1	Hagers If Under 1 Year	COWN	24 Hrs. T	O. Data of Bir		Washir		lace (State or	Foreign
Funeral Director		216-30-3735	6. Sex 7. Age 1 ☑ M 2 ☐ F	e (In yrs. last bi 76		Months Days	Hours	Min.	8. Date of Bir (Month, Da Sept • 2	y Year	1933 i	Cour Mary	rland	roreign
w w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation				-		1	0d. Inside City	y Limits
faryla r sho	ō	Maryland Washin	gton	Hager									1 □Yes	
28a-	ect	10e. Street and Number				10f. Zip Code				10a. C	itizen of Wha	at Cour	itry?	
with Sa or		17607 Woodlawn	Drive			2174	0			U	.S.A.			
ns 2:	era	11. Marital Status	12. Was Decedent 8	Ever in U.S.	13. \	_ L Was Decedent of H	ispanic Or	igin? (Spe	cify Yes or No	-	14. Race -			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evarcher must be notified at once.	by Funeral Director	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ N If Yes, Give Year or Dates:	1953 1955		fYes, specify Cuba I□Yes 2★No	Specify:		Hican, etc.)		Specify:	white, wh	etc. ite	
72 ho	ted	15. Decedent's (Specify only highest	s Education	168	. Deced	dent's Usual Occup kind of work done o	ation	t of working	na .	16b. l	Kind of Busi	ness/In	dustry	
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ind 2 sho alth and 1 27 Is ma er trauma		19a. Informant's Name/Relationsh Donna Souders -				ng Address (Street Woodlawn								40
Pages 1 sent of He nt; If Item ry or other		20a. Method of Disposition 1				sition (Name of natory or other place on Cemete			ate 19 2010		ocation - Ci		own, State Maryla	ınd
permit. P Departm Importal any Injui		21. Signature of Funerat Service L	4 4	1.		Name and Addre		ity Mir	nnich E				yland :	2174
Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	the death. Do	LON	er the mode of dyin	ng, such as	s cardiac o	r respiratory a	irrest,		1.	Approximate Interval Betv Onset and D	veen
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	AL 7 a consequence	of):	DO THOU	10pv	1-0 15	2 PL	_		1	18/112	S
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death c	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal deat		Ectopic pregnanc Other (specify)	:y				23d. Date Mont			'ear
quires that n signed build be deta	2	Part II, Other significant condition	ns contributing to death be	ut not resulting	in the u	nderlying cause giv	en in Part	1.				oute to t	he cause of d	eath? Jnknown
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an: T	ပိ	25. Was case referred to medical					26 Plac	e of Death	1 ∐ Yes (Check only	2 N	10 1 1	_ Yes	2 🗆 No	
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g Phy er thi	n H	27. Manner of Death	28a. Date of Inju	ry 28b.	Time o		ry at		28d. Describe			. ,	.,,,	
ath. r: Aft e fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	, , ,	y, rear)	Injury	_	Yes 2]No						
al or Atte after dea I Directo d in by th	Certification:	3 Suicide 6 Could not determine		ury - At home, f c. (Specify)	arm, str	eet, factory, office		2	28f. Location (City or To	Street a wn, Sta	and Number ite)	r or Run	al Route Num	ber,
	Medical (29a. Certifier (Check only one) CertifyIng 2 Medical E	g Physician: To the best Examiner: On the basis o and manner sta	f examination a	ge, deat and/or in	h occurred at the ti vestigation, in my o	me, date a	and place,	and due to the ed at the time	cause , date a	(s) and man	ner as	stated. to the cause(s)
To th within To th comp	Me	29b. Signature and title of contifier		_		29c. Licens	e number				ate signed	Α.		
25			ML			041	1/02:	2		m	AV 18	-, 8	2010	
5+1		30. Name and address of person v	who completed cause of d	eath (Item 23a	(Type,			1	OR H	100	. پېرسو د		/	
Stat	e_	31. Date filed (Month, Day, Year)	AVIIV - MC	ar's Signatur	66	MBADER	VI	w 1	KH		DOI OU		mo	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last)
William Thomas Showe, Jr. 3. Time of Death 2. Date of Death Vear Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 🗆 Ź0 Months Hours (Month, Day, Year) V. 14, 1939 Mary Land 219-36-2556 Nov. **Director** Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 204 Daycotah Avenue 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) produce stocker grocery store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Thomas Showe, Sr. Laura Virginia Kridler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lyn K. Showe Rowland - daughter 14517 Mercersburg Rd., Greencastle, Pa. 17225 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/20/10 Hagerstown, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) o migutes Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that introduced to the cause) Due to (or as a consequen Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nding k se as t IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Dav Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has page 2 No certificate 1 Yes director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 Yes ER/Outpatient 3 □ DOA ည 1 Inpatient After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

Registrar

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32. Røgistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per dr., 8904,0670972010dhb and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 21, Year **Physician** 2010 SODERGREN 7:30 a. M Mary Elizabeth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Boonsboro Charlotte's Home 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 6, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🖾 F 1921 215-14-2023 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a fire item Examinat be notified at anotes. 10d. Inside City Limits 10a, State 10b County 10c. City, Town or Location 1X Yes 2 No Hagerstown Director Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 U.S.A. 300 Northern Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 🔀 No white Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) her own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Roze Davies Amos Henry Shoup ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17335 West Washington Street, Hagerstown, Maryland Marilyn Miller - daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 25 2010 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland Rest Haven Cemetery 4 □ Donation 5 □ Other (Specify) MINNICH FUNERAL HOME 22. Name and Address of Facility of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carolac or respiratory arrest, show or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to lior as a consequence of Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) 68760 Physician/Medical Box IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Division of Vital Records, 3 Probably 4 Unknown 2 4 No icate has been significate has per significant page 2 should b 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforme certificate 2 1No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nursing Home 5 Nursing Home 5 Nursing Home 6 Other (Specify) Living Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner eath 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1 1 P atural 5 Pending thin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗹 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, 29b. Signature a

State

30 Name en

aress of person who completed cause of death (Item 23a)

32.

(Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 15 2010 Edward B. Titter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Yaure De Grace if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2 □ F Months Hours Chesapeake City Director 2-20-7851 Dec Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Ceci1 E1kton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 157 Tonys Road 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces' Black, White, etc. δ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: Specify: White 3 😾 Widowed 4 🗆 Divorced Completed Year or Date US Marines 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ age 1 and 2 should been of Health and Ments It item 27 is marked y or other traumatic e Edward B. Titter, Sr. Ethel Craig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21901Jack L. Titter / Son 1062 West Old Philadelphia Road, North East, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot May 18. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 2010 Elkton, Maryland 22. Name and Address of Facility Crouch Funeral Home South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician/ Chimi Obstauby. hain disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner (Wehn VASWIN allian unknown Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated expertises) Due to (or as a consequence of): Exami Manas attending physician and for use as the burial-trar that initiated events Duelo (or as a consequence of): resulting in death) Last Physician/Medical unknown P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the a 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ 1 Yes 2 No 3 Probably 4 Unknown División of Vital Records, should I Completed 24a. Was an 24b. Were autopsy findings available cate has page 2 s autopsy prior to completion of cause of death? this certificate 1 Yes 2 No : After this certifica e funeral director, r e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certificieted filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Mursing Home 5 Residence 6 Other (Specify) 잍 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred injury 1 Matural 5 Pending 2 🗌 No Accident Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) cai Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie

SHIVA

State Registrar SWP SWA

JUD SIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wh

MNO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:15 am A-Jau Tsai 2010 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 13320 Tamworth Lane Silver Spring Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🎗 F Hours 097177924 Director 575-89-8706 85 Taiwan Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 20904 Taiwan 13320 Tamworth Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 □ Divorced Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rong Kuai Tsai Kang Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13320 Tamworth Lane, Silver Spring, Maryland 20904 Wen Syi Lin - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State Ft Lincoln Crematory 05/19/2010 Important Brentwood. Maryland injury 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee Mo #1070 22. Name and Address of Facility Hines-Rinaul Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mure. List only one cause on each line. 23a. Part 1. Enter the d shock, or her Interval Between Immediate Cause (Final Onset and Death Physician/ Hepato Cellular Carcinoma months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) of certifier 29b. Signature and title May 17, 2010 D26707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 700 Buckingham Drive. Silver Spring, Maryland 20901 Lee, Pi

State

Registrar

31. Date filed (Month, Day,

2010

32. Registrar's Signature

10-03761 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene John P. Thatcher, III 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day May 16, 2010 0945 hrs Medical Examiner John Prentice Thatcher, III 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert 5343 Forrest Trail Saint Leonard If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Director 07/05/1950 217-60-5688 1 % M 2 F Maryland 59 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 * No Maryland Calvert St. Leonard Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5343 Forrest Trail 20685 United States Funeral 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 1 Married 1 × Yes 2 No 1 Yes 2 No specify: Specify: White 4 Divorced If Yes, Give Year 1969–1971 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Power Plant 12 Maintenance Supervisor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Prentice Thatcher, Jr. Jane Elizabeth Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamara Ann Thatcher / Wife 5343 Forrest Trail, St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 * Burial 2 Cremation 3 Removal from State Southern Memorial Gardens 05/21/2010 Dunkirk, Maryland Donation 5 Other Specify 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service Lice P.O. Box 600, Lusby, Maryland 20657 ications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. (Madica Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown hypertension Completed certificate has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No page 1 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: of Vital Be examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification 1 V Natural Division 1 Yes 2 No Pending by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) within 24 hours a determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of cort 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 18, 2010 Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Dive filed (Month, Day) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ THOMAS EMMA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Ellicott City Ellicott City Health and Rehab 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Director MD 214-34-4637 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21229 1203 Valley Brooke Court USA items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married "natural", or 1 Yes 2X No Specify: 3 X Widowed 4 □ Divorced Specify: Completed Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Worker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Carroll Dora Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Mae Parker - daughter 7921 Bright Light Place, Ellicott City, MD 21043 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 3 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Mookins UMC Cem. 4 Donation 5 Other (Specify) 5/21/10 Highland, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complication is that caused the death Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) KMENMA ysician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Be Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completed filled in by the fun Natural 5 Pending 2 No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

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31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	-	For State Registrar	Cei	tificate of D	Death		Reg. No.	0 /38/
Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Y	3. Time of Death 5:45 P. M
Medic	al	Quinella Mae Toms	-	4. 07. 7	Leading of Deal	May 2:	3, 2010	J.45 P. M
Examin	er	4a. Facility Name (if not institution, give street and number) Citizens Nursing Home		4b. City, Town, or Frederi		ın	4c. County of Frede	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	(, Year)	Birthplace (State or Foreign Country)
Director		451-34-3875 1 □ M 2 😾 F 82 Usual Residence of Decedent	115.			July 9	,1927 L	Texas
land shov	tor	10a. State 10b. County 10c. City, T	own or Lo					10d. Inside City Limits
Mary 28a-1	irec	Frederick	SWICK					1 Yes 2 □ No
be filed within 72 hours after death with the Maryland ental Hygiene. Red other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 18 West Orndorff Drive		10f. Zip Code 21716			10g. Citizen of What United S	
r death ritem iner n		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
rs after ral", o Exam	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		1 ☐ Yes 2x No	Specify:		Specify:	White
2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	ation luring most of wo	orking	16b. Kind of Busin	ness Industry
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y can	잍	Everett Cecil Muse					tchmond	
nd 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Quinella F. Miller/Daughter	19b. Maili 18 W €	ng Address (Street a est Orndo	nd Number or R rff Driv	re, Bruns	r, City or Town, Stat Wick, MD	e, Zip Code) 21716
permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important if item 27 is marked other than "n any injury or other traumatic event, the Medi		1 Durial 2 ☐ Cremation 3 ☐ Removal from State	netery, crer	osition (Name of matory or other place n Cemeter	: : : : : : : : : : : : : : : : : : : :		20c. Location - Ci	on, Texas
ermit. F Separtm mporta iny inju		21. Signature of Funeral Service Licensee	22	2. Name and Addres	ss of Facility Ke	eney and		Funeral Home
4 40 = 60		MO1222 23a. Part 1. Enter the disease, or complications that caused the death. I				_	ederick,	Approximate
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Medical Examiner		disease or condition resulting in death) a. Chronic Obs Due to (or as a consequer		ive Pulmo	nary Di	sease		
Examiner	e.	Sequentially list conditions, b. Due to or as a conscient	oo off:					
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ificate be executed g physician and as the burial-transit	I Exc	that initiated events c. resulting in death) Last Due to (or as a consequent)	nce of):					
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that the	by Ph	Part II. Other significant conditions contributing to death but not result	ing in the ι	underlying cause giv	ven in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
quires an sign	ed b	Dementia, Insulin Depende	nt di	abetes me	ellitus	. 1 🗆	Yes 2□No 3	☐ Probably 4 X Unknown
aw rec	Completed	Chronic Kidney Disease				24a. Was autor	osy prid	ere autopsy findings available or to completion of cause of
:The law						1 🗆 Yes		ath? ☐ Yes 2 ☐ No
Physician: this certific al director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inpatient 2 F	2/Ordenstin	Oth	ace of Death (Ch			(C16)
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ttending I death. ctor: After	Certificate:	2 Accident Investigation		M 1 □	Yes 2 ☐ No			
lor Att		4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fi	ledical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled only one) 3 Certifying Nurse Practioner: To the best of my knowled	nd/or inves	stigation, in my opinio	on, death occurred	d at the time, date a	ind place, and due to	the cause(s) and manner stated.
To the within To the comple	Σ	29b. Signature and title of certifier					29d. Date signed (f	
		Willy (the	-1 -7 /(/	* D005	4547		May 24,	2010
		30. Name and address of person who completed cause of death (Item 2: William J. Crittenden, MD			sen Rd.,	Suite 3	50, Laure	e1, MD 20707
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	е	bares				
				<i>m</i>				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla		artment of H			iene _{eg. No.}	10	17388
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	Physicia	an							May 20,	2010	Year	11:40 A.M
Mary.	/Medic		Bonnie Louise 4a. Facility Name (If not institution				4b. City. Town, or	Location of Death			ty of Death	11.40,00
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П	Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign
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	D >		Usual Residence of Decedent 10a. State 10b. County		100 C	ity, Town or Lo	ontion				10	0d. Inside City Limits
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	ns 23	Funeral	18636 North Ha		cedent Ever in U	J.S. 13. V		21742 lispanic Origin? (S	pecify Yes or No-		U.S.A.	
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3	urs a	þ	3 ■ Widowed 4 □ Divorced	If Yes, G Year or I	live Dates:		I □Yes 2 No	Specify:		Spec	sity: Whit	te
3-00-c	natur Iscal	Completed	15. Decedent (Specify only highes	t's Education)	16a. Dece	dent's Usual Occup	ation	kina	16b. Kind of	Business/Ind	dustry
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Mar	d 2 sl th an 7 is r traur		Lorrel V. Davis	, , , , ,			8 Amanda					Code)
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aitimor	permit. Pages 1 and 2 should be liled within 7/2 hours after death with the Maryland Department of Health and Mental Hygiene. In Important: If them Z7 is marked other than "natural", or items 23a or 28a-f show important: If them Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is "next call Experiment Insist by inclined in once.		1 Burial 2 Cremation 4 Donation 5 Other (S)		1 State			i	2/- 2010	Drotmo	i11	Marviland
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	/Medical		disease or condition resulting in death)	a. Due to	o (or as a conse	quence of):	51	Jam.				Jose
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_	g #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conse	quence of):						
	and trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to	o (or as a conse	auonae of/:						
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\	ran: rtifice stor, p	Be C	25. Was case referred to medical					26. Place of Dea	ath (Check only on			
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VISION OF	ng ra	Ë	27. Manner of eath 1 Matural 5 ☐ Pendin		e of Injury onth, Day, Year)	28b. Time o Injury	f 28c. Injur Wor	ry at k?	28d. Describe ho	ow injury occ	urred	
2	eath. or: A	cati	2 Accident investig	gation				Yes 2 □No				
<u> </u>	or At fter d Sirect in by	Certification:	4 Homicide determ	ined 28e. Plac	ce of Injury - At I ding, etc. <i>(Spe</i> c	home, farm, str c <i>ify)</i>	eet, factory, office		28f. Location (Si City or Town	treet and Nur n, State)	nber or Rura	al Route Number,
ָ ב	ours a		29a. Certifier 1 Certifyir	ng Physician: To th	an hont of my kr	nowledge deat	h occurred at the ti	me date and place	e and due to the	Pause/s) and	manner as	stated
:	Fundately is	Medical		Examiner: On the								
:	To the hospital or attending rinystcian; The law requires that the beam certification to the forms after defect. To the Teneral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Mec	29b. Signature and title of dertifie		stated.	1 1	10 29c. Licens	e number	2	29d. Date sig	ned (Month,	Day, Year)
	- s - 0		M. IL	In.		li-	_ \	117	2	ma.	. 9/	20 110
•			30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type.	Print)	1641	2 1	11 day	0-1	1 20 10
5H	-4		Hind Ha	11. 20	m Mi	1.11	30 01	DAL C	T. : 1/01	Q-PA	1011	M. M 21.14
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sigr	rature/				7		,
	Registr	ar	MAY 2	2010	The state of the s	1 1	allel			<u> </u>		

DHMH 17 Rev 1/2001

10-03788 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rickey Jay Vanhouter State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day May 17, 2010 Rickey Jay VAN HOUTER 1530 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Shady Grove Metro Yard Rockville Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 107-50-3289 Hours Director Aug, 24, 1957 country) New York 1 XM 2 F 52 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Rockville Maryland Montgomery 1 Yes 2 No "natural", or items 23a or 28a-f show Examiner must be notified at once. death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 United States 1720 Wilmart Street ö Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 3 Widowed 1 Yes 2 No specify: Yes. Give Year Divorced Specify: white or Dates 16b. Kind of Business/Industry Lynchval Systems 16a. Decedent's Usual Occupation (Give kind of work done within 72 hours 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) it. Pages I and 2 should be filed within 72 rement of Health and Mental Hygiene.
rrant: If item 27 is marked other than "y or other traumatic event, the Medical. Worldwide Computer Programmer 18 Mother's Name (First, Middle, Maiden Sumame) Lillian Jane Mables 17. Father's Name (First, Middle, Last) Emerson Levi Van Houter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1720 Wilmart Street, Rockville, MD 20852 7 19a. Informant's Name/Relationship (Type, Print) Ilene Susan Van Houter, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 05/21/10 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance Memorial Park Clarksburg, MD 4 Donation 5 Other Specify 21. Sonature of Funery Service License 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Rart Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and (Martines) Death a Complications of Diabetes Mellitus Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical ned by the attending physician detached for use as the burial -UNPENDED **AMENDED** certificate be Box 68760, IE FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Dav Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? page 1 Yes certificate Yes 2 V No To the Hospital or Attending Physician: within 24 hours after death. director, 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification 1 V Natural e Funeral Director: Division 1 Yes 2 No death. Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 O.C.M.E. May 18, 2010

Registrar

OCME 2006

State

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who complete Patricia Aronica-Pollak MD. A

31. Date filed water Day, Year) 201

ed cause of death (Item 23a)

Registrar's Signature

10-03755 Joshua Charles \		den	St	oe or Print i ate of Maryla	and / Depa	artment,	of Heal	lth an				gible	9.	17390
		Donietrar		16a per F	H, RGŒ	diffeate	oppeat	h			R	leg. No.	Some Not 1 No	
Physicia Medical Exami	ın/	1. Decedent's Nam		le,Last) RLES WAF	RDEN						Date of Dea Month ¶ay 16, 2	Day	Year	3. Time of Death 0156 hrs
				on, give street and no d South of Rt. 1				Town, or nantow	Location o	of Death	_	t t	c. County of Dear Montgomery	th
Funeral		5. Social Security I	Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Und	ler 1 Yea	_	er 24Hrs. 8	Date of Bi	rth (MM		rthplace (State or
Director		215-06-		1 M 2 F	27		Yrs. Month	ns Day	s Hours	Min.	3/01	/19	983 Fore	ountry) MD
any		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
ž .,	_	MD	MON	TGOMERY		GERMA	WOTNA	N						1 Yes 2 No
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Nu	mber			-	10f. Zip	Code			1	10g. Citi	izen of What Co	untry?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28s-f sho ent, the Medical Examiner must be notified at once.		19212	LIBER	TY MILL	ROAD			087					USF	
h with	Funeral	11. Marital Status 1 Never Marri	ad 2 M	12. Was De arried Armed F	cedent Ever in U orces?					gin? (Specif , Puerto Ric		D-	Race - Ame White, etc.	rican Indian, Black,
	〗			1 Yes	2 No	1	Yes 2	No.	specify:				Specify: WH	HITE
11215-0036 Id be filed within 72 hours after femal Hygiene. narked other than "natural", event, the Medical Examiner	<u>a</u>			or Dates:			dent's Usual	Occupa	tion (Give I	kind of work		16b.	Kind of Business	/Industry
72 hou	Completed	Elementary/Sec	ondary (0-12)	College (1-4 or 5+)					use retired)				
036 rithin rane.	du	12				SELE	EMP	FOX					SALES	
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name								's Name (Fi				
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MD 21 d 2 should Ith and Mer n 27 is man numatic ev	은	MARGARE			THER	N 1							ERMANTO	20874
imore, MI Pages 1 and 2 s nent of Health a sant: If item 27	ı	20a. Method of Dis	position			Place of Disp crematory or			metery,	Da	ate	20c.	Location - City o	r Town, State
MOF Pages ent of nt: If		1 Burial 2 4 Donation 5	_	n 3 Removal f	I OIII State	YDS (05/2	21/20) h O	BOYDS	S, MD
Baltimore, MD 2: permit. Pages 1 and 2 should Department of Health and Mr Important: If item 27 is miliury or other traumatic e.	ı	21. Signature of 5					2. Name and			AL HO	ME E	.0	BOX 8	36
		16	1. 1	complications that		- 25					E L	BARI	NESVILI	Approximate Interval
Physician Vedical		failure. List or	nly one cause	on each line.		i. Do not ente	er trie mode	or dying	, such as G	al diac of Tes	spiratory ari	1631, 311	ock, or fical	Between Onset and Death
Examiner		Immediate Cause or condition result			juries a consequence o	of):								
		Sequentially list co	onditions,	b										
	ine	if any, leading to in cause. Enter Und	mmediate		a consequence o	of):								
=	Examiner	(Disease or injury events resulting in		Due to (or as	a consequence o	of):								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	न			d						_			 -	<u> </u>
760, ficate be exe g physician t the burial -	edic	UNPENDED) 	AMENDED								Loo	d Date of delive	
Box 68760, e death certificate be the attending physic red for use as the burned for use		IF FEMALE: 23b. Was decedent			, outcome of preg birth		Fetal death	3	Ectopic	c pregnancy		23	d. Date of delive Month	Day Year
OX 687 eath certific attending properties as the	icia	past 12 month	sr No 9 □ Un	lun aven	nant at time of de	eath 5	Other (Spe	ecify)				4		
. Bo)	Phys	Part II. Other sign		9 Ulki	nown to death but not r	esulting in th	e underlyin	g cause	given in Pa	art I.	23e. Did t	obacco	use contribute to	the cause of death?
Division of Vital Records, P.O. Is or Attending Physician: The law requires that the safe death. The Trector: After this certificate has been signed by it led in by the funeral director, page 2 should be detached.	٥	Tarena Canor organ						9			1 Ye	s 2	No 3 Pro	obably 4 Unknown
ords, w require s been sign	eted					41			_		24a. Was			utopsy findings available
COF law r has b	Completed										auto perfo 1 ✓ Yes	ormed?	death?	
of Vital Recing Physician: The latter this certificate land director, page		25. Was case refe	rred to medica	al				26.Place	e of Death	(Check only		2N	1 🗸	Tes Z No
Vita ysician his cer direct	o Be	examiner?	2 No	Hospital: 1	Inpatient 2	ER/Outpation	ent 3	DOA	Other ₄	Nursing H	ome 5	Reside	ence 6 🗸 Oth	er: Scene
J of Jing Ph. After tl	-1	27. Manner of Dea		28a. Date (Mgn	e of Injury h, Day, Year) i, 2010	28b. Time	of Injury		ıry at Work	. l∩r			ury occurred	rcvcle
ion itendii leath. for: /	Certification:	1 Natural 2 ✓ Accident		estigation		0145 hrs			Yes 2 🗸	No .				
ivis or At after of Direc	tific	3 Suicide		lid not be	ce of Injury - At h			y, office	building, et					t. 118, Germantown, M
D ospital hours ineral y filled		4 Homicide		Topociny) Major Roa									
Divisior To the Hospital or Attendential 24 hours after Attendential Office for the Funeral Director:	Medical	(Check only one) 2		hysician: To the beaminer:On the basis	of examination a									
To vitl	Mec	29b. Signature and	title of certifi	and manner er	stated.		29	c Licen	se number			29d.	Date signed (M	onth, Day, Year)
		D-1	UL					O.C.	M.E.			Ma	y 16, 2010	
		30. Name and add	lress of person	n who completed cas	use of death (Iten									
		Donna M. \			Medical Exa				t, Baltime	ore, MD 2	21201			
St Regis	ate	31. Date filed (Ma	th Day, Year	2010 32.5	legistrar's Signat	ure	arke	,						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year May 13. Physician/ 8:15 ΑМ Margaret Emily Walker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Sept. 15, 1945 Washington, D.C. 578-58-1192 64 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10c. City. Town or Location 10a. State Director must be notified 1 Yes 2 X No Maryland Montgomery Germantown 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ò 23a Funeral 20874 United States 19614 Rhinestone Drive items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Examiner Armed Forces? Black, White, etc. 5 ģ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 all Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Benefits Coordinator Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ပ Elizabeth Mae Melton Vance Young 1 and 2 should to the stand Me item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19614 Rhinestone Dr., Germantown, MD 20874 19a. Informant's Name/Relationship (Type, Print) Barry Walker / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State $^{\text{May}}_{2010}^{^{\text{Date}}}$ cemetery, crematory or other place)
Restbayen
Memorial Gardens Department of Important: If it any injury or o 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of June Service Licenses 22. Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin mountain Hwy. Skkot Cody Frederick, P.A. MD 21701 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician/ Anoxic Encephalopathy disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Septicemia 48 hrs. Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transit Cystitis and that initiated events resulting in death) Last Due to (or as a consequence of): ing physician as the burial-Physician/Medical death certificate be Medication Use P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Į in the past 12 months? Month Day Year Pregnant at time of death signed by the a Unknown 9 Unknown requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic Pain Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Depression autopsy certificate has performed death? NPH 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Division of Vital or Attending Physician: after death. funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XX No ျှ 1 ™Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours Medical 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Konstantin Khludenev, M.D.

Year,

31. Date filed (Month, Day,

D 59013

15825 Shady Grove Rd., #140 Rockville, MD 20850

May 13, 2010

		1	For State Registrar	State of Maryland / D	Certificate of E			eg. No.	
	Physicia	-/	1. Decedent's Name (First, Middle, Last) John Flewellen Wal	ah			2. Date of Death	1	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give stre		4h City Town or	Location of Death	May 15,	2010 Year	8:30 A M
	Examin	er	Manor Care Potomac	et and number)	Potomac	Location of Death		Montgomery	
	Funeral Director		5. Social Security Number 6. Sex	M 2 \square F 82	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 15,	Year) 9. Birth Cou. 1928 New	pplace (State or Foreign nto) York
	nd how at	<u> </u>	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	/larylar 8a-f sl tified a	Director	MD Montgomery	Montgo	mery Villag	ge			1 🏻 Yes 2 □ No
	with the N 23a or 2 ust be no	Funeral Di	10e. Street and Number 20668 Highland Hal	l Drive	10f. Zip Code 20886		1	Og. Citizen of What Cou United Stat	untry? Ies
3036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ODGE.		1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 X No	Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: White	, etc.
Maryland 21215-0036	thin 72 hou ane. than "nat u ne Medica	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	completed) (Decedent's Usual Occup Give kind of work done of ife. DO NOT use retired) Lrector / Ur	during most of work	ng	16b. Kind of Business I $_{ m NBC}$	ndustry
0 5	iled wii I Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)	2		18. Mother's Nam	e (First, Middle, M	laiden Surname)	
ylan	d be fi Menta arked artic ev	욘	John Walsh				1eweller		20006
, Mar	d 2 shoul salth and n 27 is m er trauma		19a. Informant's Name/Relationship (Type Doris Walsh / Spou	.se 206	Mailing Address (Street a	and Number or Rura	ive Mont	gomery VII.	Lage, MD
Baltimore,	Page 1 an nent of He int: If iten iny or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State cemetery	Disposition (Name of crematory or other place al Cremato)	o5/18	/2010 _F	20c. Location - City or alls Churcl	h, VA
Balti	permit. I Departri Importa any inju	d	21. Signature of Funeral Ser A Licensee	Mun	22. Name and Addres	ss of Facility Jos nsin Ave.	eph Gawl NW Wash	er's Sons : ington, DC	Inc. 20016
	husisian/		23a. Part 1. Enter the disease, o complic shock, or heart failure. List only one Immediate Cause (Final			g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Proset and Death
- u	Physician/ Medical		disease or condition resulting in death)	Due to (or as a consequence of):				
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	icate be executed I physician and Is the burial-transit	cal Ex	that initiated events c. resulting in death) Last	Due to (or as a consequence of	η:				
3760		Medi	IF FEMALE:						
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of deli Month	lvery Day Year
, P.O.	es that the signed by be detacl	by	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause gi	ven in Part I.		pacco use contribute to	the cause of death?
cords	law requir nas been s s 2 should	Completed	T TO GING TEAC				24a. Was ar autops perfort	by prior to d	copsy findings available completion of cause of
Re	n: The ficate I		25. Was case referred to medical		26 D	lace of Death (Chec	1 🗆 Yes		2 🗆 No
Vita	ysiciar s certii directo	To Be	avaminar?	spital: 1 ☐ Inpatient 2 ☐ ER/Out	Oth	or:		ence 6 Other (Speci	(fy)
n of	nding Phy th. : After thi e funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury 28b. Ti	jury work	y at k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division of Vital Records,	al or Atter s after dea il Director ed in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office		28f. Location (St City or Town	reet and Number or Rui 1, State)	ral Route Number,
_	ne Hospita n 24 houn ne Funera pleted fille	Medical	(Check 2 Medical Examine	ian: To the best of my knowledge, or: On the basis of examination and/or Practioner: To the best of my knowle	investigation, in my opini	on, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated
_	within To the Com		29b. Signature and title of certifier		29c Licens	e number) 2	9d. Date signed (Month	
	25		30. Name and address of person who cor	replaced cause of death (Item 22c) (7	(vne Print)	1007		05/17/20	110
			Raman Tuli MD 1081			ersburg,	MD 208	78	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 18 2010	32. Registrar's Signature	arked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hydrene 8 #14perDVR Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 07Day Month Physician/ :00a M Arthur Beau White 2010 May Medical 4a, Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner 9613 Barroll Lane Kensington Montgomery 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** July 26, 1 🕅 M 2 🗆 F Days Hours 251-46-9028 79 1930 South Carolina Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD Montgomery Kensington 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral 23a 9613 Barroll Lane 20895 United States er than "natural", or items 23, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian African Black, White etc. American 1 Never Married 2 Married þ 1 X/es 2 No 1954-If Yes, Give within 72 hours after Maryland 21215-0036 1 Yes 2 XNo 3 Widowed 4 Divorced Completed 1956 Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Research Scientist **Health** 5+ other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Banneker White ၉ Marie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holley Brandchaft-White/Daughter 9613 Barroll Lane, Kensington, MD 20895 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 4 Donation 5 Other (Specify) Chesapeake Crematory | 05/18/2010 | Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. Joanna 7400 Georgia Avenue, N.W. Washington, DC 20012 23a. Cart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final gn Physician/ Prostate Cancer years disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury Due to (or as a consequence of) Examin attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be det 23e. Did tobacco use contribute to the cause of death? [호 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\subseteq\) Nursing Home \(5 \) Residence \(6 \subseteq\) Other (Specify) 2 No 1 Yes 읻 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending r death. 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after filled

Registrar DHMH 17 Rev 7/2009

State

Funeral

24

within 2

Medical

29a, Certifier

(Check

Leon &

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Hwang, M.D.

Gertifying Nurse Practioner: To the best of my knowle

ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D45880

1396 Piccard Drive, Rockville, MD 20850

29d. Date signed (Month, Day, Year)

May 12, 2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			State of Maryla 27,28a-f pe				-	-	17394	
Physicia Medic		1. Decedent's Name (First, Middle, Last) Paul G. H. Wolber					2. Date of Death Month Day 2 2 2 10 1149 4 M			
Examin	er	4a. Facility Name (If not institution, give street and number) Washington County Hospital			4b. City, Town, or Location of Death Hagerstown			4c. County of Death Washington		
Funeral Director		5. Social Security Number 6. Se 301–03–3060 Usual Residence of Decedent	7. Age (In yr M 2 \square F 95	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month Day)	Year) C	irthplace (State or Foreign ountry) ennsylvania	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	rector	10a. State 10b. County MD Washingto		City, Town or Lo					10d. Inside City Limits 1 √ Yes 2 □ No	
	Funeral Director	10e. Street and Number 1175 The Terrace			10f. Zip Code 21742			10g. Citizen of What Country? U.S.A.		
	by	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.			13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	(Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed)		Decedent's Usual Occupation Sive kind of work done during most of working fe. DO NOT use retired) DC COT			16b. Kind of Business Industry Medical		
	To Be	17. Father's Name (First, Middle, Last) Henry Frederick Wolber			18. Mother's Name (First, Middle, Ma Wilhelmina Amar			_ ′		
nd 2 shou lealth and m 27 is m her traum		19a. Informant's Name/Relationship (Typ. Gwendolyn Hatters	ley/ daughte	er 1061	6 Robert		ral Route Number, C Hagerstow	City or Town, State, 2	Zip Code) 742	
Page 1 a tment of H tant: If ite jury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State		sition (Name of natory or other placen Cemeter	· .	Date 2 27, 2010	Oc. Location - City of	or Town, State	
permit Depar Impor any in		21. Signature of Funeral Service License S. Mark Su	W	1		sylvania	Ave., Has	n Funeral gerstown,		
To the Hospitalior Attending Physician: The law requires that the death certificate be executed within 24 hours after det.th. To the Funeral Director. After this certificate has been signed by the attending physician and morphisms of the funeral director, page 2 should be detached for use as the burial-transit or page 2.		23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one fause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) a. Due to (or as a consequence of):							Interval Between	
	Physician/Medical Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.								
		resulting in death) Last	Due to (or as a conse	equence of):						
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1					23d. Date of delivery Month Day Year		
	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca								
	Completed by	Right hip no	on displaced	+700	hanter t	acture	perform	prior to ed? death?	utopsy findings available completion of cause of	
	Be	25. Was case referred to medical examiner? 1 X Yes 2 No	26. Place of Death (Check only one) Hospital: Other: Other:							
er ding Phy צי th. יי After this	Certificate: To	27. Manner of Death Natural 5 Pending Accident Investigation Suicide 6 Could not be Homicide determined	28a. Date of injury (Month, Day, Year) 05/14/2010 28b. Time of injury 10:30 pM 28c. Injury at work? 1 □ Yes 2 ★ No				Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred Subject fell.			
the Hospital or Att. thin 24 hours - fter de the Funeral Director mpleted filled in by t	al Certi		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home			28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 75 The Terrace, Hagerstown, MID				
	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
Jo wit		29b. Signature kipufitte of certifier	hum	MS	alcalicense	1000 A		d. Date signed (Mon $05/21/$	th, Day, Year) 1 20/0	
1-20+1		30. Name and address of person who co Shahid Mahim	md 580	Nort	1	AVR HO	2(cr)town	1 _ 1	21742	
State Registra	_	31. Date filed (Month, Day, Year) MAY 2 5 20	32. Registrar's Sign	nature	land					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 13, Physician/ Ralph B. Will 2010 8:50 P Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2215 Luzerne Avenue Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Jan. | Jan. | 1929 | Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F 81 198-20-3174 Yrs **Director** Usual Residence of Decedent 28a-f show 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 ☐ Yes 2X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 2215 Luzerne Avenue 20910 USA Was Deceue... Armed Forces? 1 ☑ Yes 2 ☐ No "Vas Give 1962–1968 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) Nuclear Medical Technician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I ည Wilmer L. Will Elsie P. Kinzey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i William C. Will / Son 15401 Peach Orchard Road, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery May 19, 2010 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins F
500 University Blvd., Signature of Funeral Service Licens Funeral Home, Inc. ., W., Silver Spring, MD 20901 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Myocardiac Infarction Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Mellitus II Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examin Hypertension physician and s the burial-trans Due to (or as a consequence of): Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 No ed by the a 9 Unknown has been signed to a subsect to the subsect tof the subsect to the subsect to the subsect to the subsect to the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy page certificate 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending injury 1 Yes 2 No s after death.

I Director: A

d in by the fu M Accident Investigation 6 Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours at To the Funeral D completed filled in Hospital Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

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Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

6900 Georgia Avenue NW, Washington, DC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Cpt. Alan Wu, MD 31. Date filed (Month, Day, Year) MAY 19 VA 0101245546

May 17, 2010

20307

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1132 Roy WAGAMAN William AM May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Washington County Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Months Hours (Month, Day, Year) 48 61 Pennsylvania 182-40-6110 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature!" any injury or other traumatic events. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Room 4426 21740 U.S.A. 50 Summit Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates. 1 X Never Married 2 Married Completed by white 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Booz John R. Wagaman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2073 Sifield Greens Way, Sun City, Florida 33573 Susan M. Kling - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date ¹³2010 1 Burial 2 X Cremation 3 Removal from State Hagerstown, Maryland 4 Donation 5 Other (Specify) Hagerstown Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home To. 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. GANGRENOUS SMALL BOWEL Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death)) Medical Examiner Due to (or as a consequence of): EPTI SHOCK Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury RESPIRATORY PAILURE Exami been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last RENAL FALLURA Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 🗆 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: (Month, Day, Year) 5 Pending 1 A Natural 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier HAMMED AZ12 D66892 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Y 251 E. Antietam St., Hagerstown, MD

Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day ROBERT WALKER MAY 2:35P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. Sept. Pay Year) 1925 303-20-7541 84 Indiana Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Barbara Street 21701 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 Tes 2 XNo Specify: 3 X Widowed 4 □ Divorced If Yes Give WWII Specify: White Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Microbiologist U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Orville Walker Anna Myrtle Zike 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Walker / Daughter 200 Barbara Street, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Resthaven Mem. Garden's 5/18/10 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland . Signature of Fundral Service Lice ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. NORTH MARKET STREET, FREDERICK. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the. Onset and Death Immediate Cause (Final Ph sician/ e disease or condition Medical Examiner resulting in death) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown After this certificate has been signed by the funeral director, page 2 should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🔀 No Other: မ 1 Yes 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Prantioner: To the best of my knowledge of the time, deterand plane 29b. Signature and 29d. Date signed (Month, Day, Year) -13-2010 MDD 64910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Frederick, MD 21701

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Registrar

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Kenneth Zawatsky May 8:01 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9119 Marseille Drive Potomac Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Jan. 10,1935 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 T New York Director 130-26-8771 75 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 X Yes 2 No MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 9119 Marseille Drive 20854 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 19 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 2 1358 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Development Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be Julius Zawatsky Frieda Block 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sylvie Zawatsky/Wife 9119 Marseille Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Lebanon Cem. 5/17/2010 Adelphi, Maryland Signature of Funeral Service Ligensee M01597 22. Name and AddresEdwand Sagel Funeral Direction, Inc. MCGreens Melissa Greenhut 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final Non Small Cell Lung Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 🗌 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 XNO ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending injury X Natural 1 ☐ Yes 2 ☐ No M Investigation Accident Suicide 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Joseph M. Haggerty MC D32407 May 16, 2010

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Joeseph M. Haggerty M.D. 9707 Medical Center Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 18 2010

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 6:45 P.M 2010 Janice Louise Armstrong June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 606 Churchill Rd. Harford Bel Air 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖾 F 236-22-0645 85 Director 11, 1925 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f shov Director 1 Yes 2 No Marvland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 606 Churchill Road Apt. C 21014 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Specify: δ 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 17 is marked o traumatic eve John Porter Bowen ပ Leona Elizabeth Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Anne L. Piluk / Daughter 11 Owens Landing Ct., Unit B, Perryville, MD 21903 of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdn. 6-5-10 Aberdeen, Maryland 22. Name and Address of Facility.
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cullen luase disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending s after dec. ral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20NE 3 , 5CAG 03225

State

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

Registrar

615 W. MACPHAIL

Below Ma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

DRVID

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town or Location of Death 4c/County of Death 4a. Facility Name (If not institution, give street and number Examiner 120 TIMORE If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number (In yrs. last birthday, Date of Birth (Month, Day, 9. Birtí place (State or Foreign Age **Funeral** Months Days Year -10 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, its Medical Evan is a notified at once. 10d. Inside Offy Limits 10b. County 10c. City, Town or Location 10a State 1 Dres 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Str 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unkrown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Morse Theron ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N.C. 2757 19a. Informant's Name/Relationship (Type Business Highway Smith daya or Town State 20b. Place of Disposition (Name of cametery, crematory or other 20c. Location - Cin 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 | Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each like. Do not enter the mode of dying, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding housing and Due to (or as a consequence of) eral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions thot resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 4 Donknown 1 🗌 Yes 2 | No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 🗌 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated. 29b. Signature and fitle of 29d. Date signed (Month, Day, Year) 29c. License number Ò 30. Name and address of person Ause of death (Item 23a) (Type, Brint) 31. Date filed (Monlif, Day, gistrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** JACQUELINE ODELL BROWN-CLARK June 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A402 EDGEWOOD STREET BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2XX Director 3 1954 MARYLAND 56 JAN 215-60-3082 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Engines must be notified at 1 XYes 2 No Director MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 402 EDGEWOOD STREET U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1XXNever Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade INSURANCE AGENT INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ODELL BROWN SYLVESTER GRAHAM BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 9 N. Abington Ave., Baltimore, Md., Shonda Swope/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 06-09-10 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND METRO CREMATORY 21. Si maure of Funeral Service Licent 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** Metastatic breast concer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit that the death certificate be executed Exami Due to (or as a consequence of): Box 68760 physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 Unknown signed | I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 👿 No 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Saranya

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UMM

32. Registrar

Chomsii, MD

068009

22 S. Grene street Rm S9DISB

2010

Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0:34 PM ores May 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Memorial Union HOSPI . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 Months Hours Min. 65 **Director** Vanio Usual Residence of Decede or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 □ No ō 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be n Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced "natural" Completed th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education cify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 1 and 2 should be filed w of Health and Mental Hygle item 27 is marked other Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, 2 19a. Informant's Name/Relationship (Type, Print) Laaightes 19b. Mailing Address (Street and Number or Rural Route Number, permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t other 1 Baltimore, 20c. Location - City or Town, State Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician, Hortic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 month Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ►No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? eral Director: After this certificate I filled in by the funeral director, page 2 🗌 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 🗆 Certifying Nurse Practioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and addre ss of person who completed cause of death (Item 23a) (Type, Print) N. Carvert St. Bolto MD 21218 Fi OC 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 10:58 AM 2010 Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) Examiner 4c. County of Death TOWSON Baltimore 109 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. -40-91 1 🗆 M 2 🖎 Months Hours (Month, Day, Partimore 215-40-9162 Usual Residence of Decedent Director Yrs ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Nes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 2 100 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ္ 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) Brec kenridge TMO Sti 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 2010 Wings 4 ☐ Donation 5 ☐ Other (Specify Fores 21. Si natu f Funeral Service Li 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final PANCKYATIC CANCER Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗀 No 1 Tyes Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 | Homicide determined Medical 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 264395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A DANIEUE DOBERMAN, 6701 N CHAPLES ST, SUITE 4105 BALTIMOLE, MD 21204 MO

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 04 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHEVERL HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Months Days **Director** 0 Usual Residence of Decedent 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event "to once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ARRIOR FAMILY CEM 5 JUNE 10 ROSE HILL, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME Signature of Funeral Service License GUILFORD Rd. LESSUP MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRHYTHM Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner P51. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events.) Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and the burial-transi that initiated events resulting in death) Last P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 \(\sum \) Yes 2 \(\overline{\mathbb{N}} \) No Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 🗌 Yes 2 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Datersigned (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Monti

10-03982 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 174 Antonio Cortez Bernard State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 3. Time of Death Month Day May 25, 2010 **Medical Examiner** 0018 hrs ANTONIO CORTEZ BERNARD 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death tc. County of Death 5704 Old Court Road Randallstown **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Director Months Hours Min. Country) MD 1 X M 2 F Yrs 220-23-4885 1988 DEC. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f Zip Code 10g. Citizen of What Country ō 5704 OLD COURT RD 21244 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items ? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc 1 X Never Married 2 Married 1 Yes 2 X No 3 Widowed Examiner 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: BLACK þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet other traumatic event, the Medical MATERIAL HANDLER RETAIL 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) Be MARK BERNARD ADRIANA E. SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK BERNARD/FATHER 1005 N. BROADWAY - APT. BALTIMORE, MD 21205 Α. 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 5500 O'DONNELL ST. 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify 06/04/2010 BALTIMORE, MD 21224 TRINITY 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. 2007-09 EASTERN AVE., BALTIMORE, 21231 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear or complications that caus Approximate Interval **Physician** 23a. Part I. Enter the dise failure. List only one Between Onset and /Medical Immediate Cause (Final disease Death Asp**k**yxia by <u>hanging</u> Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician and detached for use as the burial - transit Physician/Medical **X**UNPENDED per ME g904 6/22/10 TT ,28a-f, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Fourtail Director: After this certificate has been signed by the attending physici are viewel Director. After this certificate has been signed by the attending physici are viewell birector, page 2 should be deached for use as the burning. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 仑 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Mursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural subject hanged self Division 5 Pending 1 Yes 2X No Fd 0012 5/25/10 Fd Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 7 0 4 OLd Court Rd 6 X Could not be Suicide determined other Randallstown, Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 25, 2010 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registra, s Signature

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State Registrar

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	shook, or heart failure. List only Immediate Cause (Final	one cause on each lin	ne.	vdi	= 1 7	_ /				Interval Between Onset and Death
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edica	(Check 2 Medical Exan	niner: On the basis of e	examination	n and/or inve	stigation, in my opi	nion, death occurr	ed at the time, date	and place	e, and due to the	cause(s) and manner s
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The County of th	Medical Certificate: To Be Completed by Physician/Medical Examiner	1. Decedent's Name (First, Middle, Lateral Section of Part II. Marital Status 1. Marital Status 1. Never Married 2	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (if not institution, give street and number) 5. Social Security Number 6. Sex 1	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (if not institution, give street and number) 5. Social Security Number 6. Sex 1 M 2 F 7. Age (in yrs. 1) 10a. State 10b. County 10c. Cit 10c. Cit 10a. State 10b. County 10c. Cit 10b. County 10c. Cit 10c. Cit 10b. County 10c. Cit 10b. County	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (if not institution, give street and number) 5. Social Security Number 10	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location 1co. Street and Number (if not institution) 1co. Street and Number (if not institution) 1co. Street and Number (if not institution) 1co. Street and Number (if not institution) 1co. Street and Number (if not institution) 1co. Street and Number (if not institution) 1co. Street and Number (if not institution) 1co. Street and Number (if not institution) 1co. Street and Number (if not institution) 1co. Street and Number (if not institution) 1co. Street and Number (if not institution) 1co. Street (if not institution) 1co. Stre	4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4b. City, Town or Location of Disaster of Decedent 10b. State	4a. Facility Name (Frest, Middle, Last) 4a. Facility Name (Frest, Middle, Last) 5. Social Security Numbers (Last) 5. Social Security Numbers (Last) 6. Sec. 1	Decident's Name (first Middle, Last)	December 1 Security Name (if not institution, give sized and number) Social Security Name (if not institution, give sized and number) Social Security Name (if not institution, give sized and number) Location of beath As Facility Name (if not institution, give sized and number) Location of beath As Facility Name (if not institution, give sized and number) Location of beath Location of beath As Facility Name (if not institution, give sized and number) Location of beath Locat

DHMH 17 Rev 7/2009

Kevin Belton 10-04160

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Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle, Last) Kevin Belton		May 31, 201	ay Year 3. Time of Death 1900 hrs
7		4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center	4b. City, Town, or Location of Dea Baltimore	th	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 218-84-4188 1 M 2 F Usual Residence of Decedent	rthday) If Under 1 Year If Under 24H Months Days Hours Mi Yrs.	_ , `	MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maylan
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5 E E E			of Disposition (Name of cemetery, atory or other place) Brown Fun Hame 6	Date 21	oc. Location - City or Town, Stated Balfimore, Marylana
		21. Signature of Funeral Service Licensee July 1 23a. Part I. Ehter the disease, of complications that caused the death. Do n	22. Name and Address of Facility Pa 3512 Frederick	Ker Fun Tve. Ball	eval Home P. A. ZIZ nave Mayland shock, or helart proximate Interva
Physician /M dic I Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Stab Wounds	or enter the mode or dying, such as cardiac	or respiratory arrest,	Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		past 12 months:	2 Fetal death 3 Ectopic pregn 5 Other (Specify)	ancy	23d. Date of delivery Month Day Year
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or			
To Too	Me	29b. Anguardure and title of certifier Assurable 1000	29c. License number O.C.M.E.		Od. Date signed (Month, Day, Year) une 1, 2010
3/	Ì	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 11	1 Penn Street, Baltimore, MD 212	201	
Sta	ate	31. Date filed (Month, Day, Year) 32. R gistrar's Signature			

DHMH 17 Rev 1/2001

JUN 04 2010 Server S. Jakes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Veat 1414 Mary Lee Ballard JUNG 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Yea Oct . 1 , 1 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign MD Country) **Funeral** Hours 1 M 2 L Min. 2712 212 42 65 Director T944 Usual Residence of Decedent "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director n/a Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 1315 N. Aisquith St. Funeral USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. ğ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore County permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Auditor Financial Dept. Government yrs Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Morris Frank Johnson Harriet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (husband) Iszard Ballard, 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Balto, Md Aisquith 20a. Method of Disposition Date 2010^{0c.} Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) King Memorial Pk. Baltimore, Md. injury (June 10, onature of Funeral Service Licensee calvin B. Scruggs Funeral Home 23a. Part 1. Enter the disease, or complications that caused the pear. Do not enter the mode of dying, such as cardiac or respiratory arrest Balto, Md Approximate interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Cancer disease or condition resulting in death) DNA Medical Due to (or as a consuluence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ause (Disease or imjury attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Dav Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 □ Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform certificate 1 Yes 2 No 1 🗌 Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No Hospital Other: Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No injury Natural 5 Pending s after death. 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 🗌 Homicide determined 24 hours a Funeral L Medical 1/A/Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 JUNG 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hos

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month,

Day, Year)

04 2010

32. Registra 's Sign;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 1:00 PM 01 Medical Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death Examiner Secours 405 Himor If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth g. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) Funeral Days Min. 1 🗆 M 2 🖫 Director 217-70-0186 ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 **W**∕es 2 □ No Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 rayson 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, PO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) tician Be Maiden Surname me (First, Middle ည Informant's Name/Relationship City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, cremator 4 ☐ Donation 5 ☐ Other (Specify) oudon 21. Signature of Funeral Gervice Licencee 23a. Part 1. Enter tig disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition) Medical resulting in death) r as a consequence of Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No Yes 25. Was case referred to medical examine?

1 Yes 2 \(\sum \) No **Division of Vital** funeral director, 26. Place of Death (Check only one) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident 5 Pending within 24 hours after death. To the Funeral Director: A Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide completed filled in by determined City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 W. Baltimore Stree Benn- Thompson, MD Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2010 2:15a Carroll Woodruff Church Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Center Baltimore Catonsville 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 🕱 M 2 🗆 F Months Hours Min. Feb. 26. 1926 Director 214-20-0496 84 Usual Residence of Decedent show at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director or 28a-f sh notified a 1 Yes 2X No Marvland |Baltimore Catonsville 10f. Zip Code 10e, Street and Number 10a. Citizen of What Country? 5 er than "natural", or items 23a of the Medical Examiner must be Funeral 1903 Tadcaster Road United States 12. Was Decedent Ever in U.S.
Armed Forces? Unk

1 1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Divorced 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) h and Mental Hygiene. It is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked cary injury or other traumatic evenone. ပ Mary Ε. Sanner Christian C. Church 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Tadcaster Road, Catonsville, Maryland 21228 Betty J. Church, Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 6/4/2010 Baltimore, Maryland oudon <u>Park Cemetery</u> Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cemi Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): 60 Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) ☐ Pregnant a the a Unknown be detach signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗆 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 certificate 1 ☐ Yes 2 ☐ No Yes 2 X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ၉ 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred After iniury 5 \square Pending X Natural Accident Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) $O_{\chi_{I}}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fernandez, M.D., 516 N. Rolling Road Ste. 205, Baltimore, MD 21228 Dr. Rodolfo E. 31. Date filed (Month, Day, Year) 32. Restrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Mary Virginia Clary 2. Date of Death 3. Time of Death June 3, Year **Physician** 2010 3:30 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Brinton Woods Nursing Home Sykesville Carroll Birthplace (State or Foreign Country) 8. Date of Birth 10/11/1919 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 1 □ M 2 1 F Months Days Hours Min. 90 MD**Director** 212-32-3696 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "Notical Exeminar must be notified at 1 ☐ Yes 21 No Director MD Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 4410 Salem Bottom Rd. 21157 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>ک</u> 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker her home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe and Mental Orlando R. Farver Ella Mae Frizzell ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 4410 Salem Bottom Rd. Westminster, MD 21784 Virginia Crosswhite (daughter) 20c. Location - City or Town, State Date 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) XX Burial 2 ☐ Cremation 3 ☐ Removal from State 6/7/2010 Taylorsville, MD 4 Donation 5 Other (Specify) Taylorsville Cem. 22. Name and Address of Facility Burrier-Queen funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRONIC OBSTRUCTIVE talmena Physician 91 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: the Hospital or Attending Physician; The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.O. signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed' certificate 2 INO 1 Yes 2 Ho 1 Yes this certifical director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

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State Registrar 29b. Signature and title of certifier

TRICK 31. Date filed (Month, Day, Year)

Wellen and address of person who completed cause of death (Item 23a) (Type, Print)

RNS, UD

114

BUSINESS CTR DR

29c. License number

29d. Date signed (Month, Day, Year)

REISTORSTOWN

2010

			Amend 4c per MD G90 Please Ty 1 - State Amend # 10b &	4 6/29/10 TT Pe or Print in E	lack in	delible Inl	71 572016	All Copie:	s Are Le	gible.	. =11.1.0
				10d, per Fh	G904e6	irtment of F 129/10 T tificate of L	eaith and	Mental Hy	gienez () Reg. No.	10	1/412
	Physicia	ın/	Decedent's Name (First, Middle, Last) John	S.	Cai	ringto	0	2. Date of Dea Month	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give stre		Cal	4b. City, Town, or		1 06		2010 ty of Death	3:30p.™
~	,		201 Walnut Ave				dalk			imore	
	Funeral Director		5. Social Security Number 227-20-8297 Usual Residence of Decedent	7. Age (In yrs. las	t birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day 08 14	th y, Yea <i>r)</i> 4 24	9. Birthp Count	olace (State or Foreign try) VA
	1 and 2 should be filed within 72 hours after death with the Maryland freath and Mental Hygiene. **Health and Mental Hygiene. **The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	10a. State 10b. County		Town or Loc					1	0d. Inside City Limits
	the N a or 2 be no	٥	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	try?
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5-0036	irs afte iral", I Exan	Completed by	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates.	1	☐ Yes 2 📉 No	Specify:		Specia	fy: B 1	ack
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	filed v	Be C	17. Father's Name (First, Middle, Last)					ne <i>(First, Middle,</i> Hunt			
Maryland	should be filed within 72 hours aft and Mental Hygienal 'is marked other than "natural", 'aumatic event, the Medical Exar	입	John I. Carring				Marion	Hall			
2	2 sho Ith and 27 is r traun		19a. Informant's Name/Relationship (Type, Vivian Carringt	· ·		g Address (Street a Walnut					Code)
~	of Heal of Heal fitem		20a. Method of Disposition	20b. Pla	ce of Dispos	ition (Name of atory or other plac		Date	20c. Location		wn, State
altimore,	nit. Page artment o ortant; If injury or		1 Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)			n Fores	1	/2010	Owing	s Mi	lls, Md
Balt	permit. Page 1 and Department of Hes Important: If item any injury or othe once.	1	Signalure of Funeral Service Licensee	Align	IМа	Name and Address	West				
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P	nysician/	\	soock, or heart failure. List only one c Impediate Cause (Final	ause on each line.	1.	c Cos	SINIS	uer.	c A		Interval Between Onset and Death
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_]	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a conseque		1000	1206	200			
9	sician and		that initiated events c. a resulting in death) Last	Due to (or as a conseque	nce of):						
	physician the buria	dica	d. ,								
Box 68760	rnystotan: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE:	If yes, outcome of pregnand	:v						
XO	atten for us	iciar	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fetal 6	death 3 🗌	Ectopic pregnance Other (specify)	У			ate of delive Ionth	ery Day Year
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al H	certificate ector, pag		25. Was case referred to medical examiner?			26. Pla	ce of Death (Che	1 L Yes	2 No	1 Yes	2 ∐ No
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Division of Vital Records,	aing r h. After 1 funera	ate:	1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury work' M 1 🗆	at ? Yes 2 🗆 No	28d. Describe h	ow injury occu	rred	
isio	after death. Director: After din by the fune	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At hom	e, farm, stre		163 2 110	28f. Location (S		ber or Rural	Route Number,
Div.	irs after or all Direction led in led			building, etc. (Specify)				City or Tow	<u> </u>		
1	to the nospital or Attending Finding Attending Properties of the Funeral Director: After this completed filled in by the funeral	Medical	(Check 2 L Medical Examiner:	n: To the best of my knowled On the basis of examination a	and/or investi	gation, in my opinio	n, death occurred	at the time, date a	nd place, and d	ue to the cau	se(s) and manner stated.
	vithin 2 To the comple	Σ	only one) 3 ☐ Certifying Nurse Po 29b. Signature and title of certifier	actioner: To the best of my k	rnowledge, de	29c. License			e cause(s) and n 29d. Date sign		
			RexBX	angeon	Tro	101-	F753		6/3	oils	
	(X)		30. Name and address of person who comp	eleted cause of death (Item 2	3a) (Type, Pr	int) Robe	LT B.K	200 BUTA	KIMA	1100	will a
	Stat	e.	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	<u>-00</u>	رن ر ن		30-1,	,, ,,	0000	-C. on yall
	Registra		JUN 0 4 2010 1	went d. s	arte	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 31 2010 1340 p M EUGENE CALVIN CHANDLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HARFORD CO UPPER CHESEAPEAKE MEDICAL CENTER BELAIR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT • 22 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Sex XXM 2□F Months Days Min. Hours NORTH CAROLINA 81 Director <u>24</u>0-32-6277 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or than "natural", or items 23a or 28a-f show the Modical Experient must be notified at 1 ☐ Yes 2XXNo Director MARYLAND HARFORD CO ABERDEEN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 343 MT ROYAL AVENUE 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Ves 2 □ No If Yes, Give Year or Dates: 51/71 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married land 21215-5036 1 ☐Yes 2 No Specify: Completed by Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry of Health and Mental Hygiene.
item 27 is marked other than "natuother traumatic event." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12yrs PRIVATE INVESTOR PRIVATE 6yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 CHARLIE CHANDLER ARABELL COFIELD CHANDLER Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inez B. Chandler/Wife 343 Mt Royal Avenue, Aberdeen, Md., 21001 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages Important: If it any injury or o 1 X Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL 07-15-10 ARLINGTON, VIRGINIA Funeral Service 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, S PHILADELPHIA BLVD, ABERDEEN, MD 21001 Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. shock, or heart failure Immediate Cause (Final **Physician** ION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a 2 **1 1 1 1 1** 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vitaf/Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? Anom 24a. Was an autopsy The page 2 0 NO 1 ☐ Yes 2 ☐ No 1 ☐Yes Physician: 25. Was case referred to medical funeral director 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manne Leath 28b. Time of Mandula Division o 28d. Describe how injury occurred Hospital or Attending 1 A Natural 5 Pending 1 □ Yes within 24 hours after death To the Funeral Director: 2 Accident investigation the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NES reen Kuttom 500 Upper Ch
31. Date filed (Month, Day, Year) 32. Registral's Signature State Registrar DHMH 17 Rev 1/2001

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			For State	State of Maryland	•		Mental Hygie	ne	
			Registrar		Certifica	te of Death		. No.	·
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Wallace 3.	1	i	*11	2. Date of Death Month	Day Year	3. Time of Death
	Medic		4a. Facility Name (if not institution, give str		hurch	v. Town, or Location of Death	5	23 2010	·
	Examin	er	Baltimore, VA	,	Center	Baltime		,	more
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	Months	er 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		nplace (State or Foreign
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	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	faryla Ba-f s tified	ect	Md NIA	1 B	altime	oro.			1 X Yes 2 □ No
	the N or 20	₫	10e. Street and Number	Apt	10f. Z	ip Code	100	. Citizen of What Co	untry?
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and	oe file intal F ced of	10 B	17. Father's Name (First, Middle, Last)	verabill		18. Mother's Nar	ne (First, Middle, Mai	den Surname)	
ير	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type	Print) (Friend)	19b Mailing Addre	ss (Street and Number or Ru	ral Route Number. Cit	tv or Town. State. Zip	Code)
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ore,	1 and of Heal item :		20a. Method of Disposition		ace of Disposition (Nametery, crematory or		Date 20	c. Location - City or	Town, State
<u>=</u>	Page 1 nent of ant: If it ury or o		1 A Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Dopetion 5 ☐ Other (Specify)	emoval from State	rrison	torest 6/3/	2010	wings 1	Mills, Md.
Baltimore, Maryland 21215-0036	permit. Page 1 and 3 Department of Heali Important: If item 2 any injury or other once.		21. Sign of Funeral Service Licens	1	22. Name a	and Address of Facility	Juneral 1	tome, PA	
ш		1 4	Laysey X	Tay	2222	N. North Av	e part	5. MZ! 21	216
			23a. Part 1/ Enter the disease, or complic shook, or heart failure. List only one Immediate Cause (Final	cause on each line.			or respiratory arrest,		Approximate Interval Between Onset and Death
P	nysician. Medical		disease or condition resulting in death)	Aspiration		אטחומ			5.1.00 tal. a. 20a
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90	eath certificate be exvattending physician for use as the burial	dic	d.				<u> </u>		
P.O. Box 68760	ertific ding p	Physician/Medic	IF FEMALE: 23	c. If yes, outcome of pregnan	CY			23d. Date of deli	ven/
ŏ	atth c atten for us	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopia			Month Month	Day Year
B	the de by the ached	hysi	9 Unknown	9 Unknown					
9.	that med be e deta		Part II. Other significant conditions cont	ributing to death but not resu	Iting in the underlying	g cause given in Part I.		cco use contribute to	
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Division of Vital Records,	aw re las be	Completed by					24a. Was an autopsy	prior to d	opsy findings available ompletion of cause of
Be	: The cate h						1 Yes 2	d? death? ☐ No 1 ☐ Yes	2 ☑ No
ta	ician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:		26. Place of Death (Che			
<u>`</u>	Phys r this gral dii	e: To	27. Manner of Death		28b. Time of	DCA 4 Nursing F 28c. Injury at	lome 5 Residence 28d. Describe how	e 6 Other (Speci injury occurred	fy)
n c	nding ath. :: Afte e fune	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury M	work? 1 ☐ Yes 2 ☐ No		, ,	
isic	· Attel er dez ector by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, facto	ory, office	28f. Location (Stree City or Town, S	et and Number or Rur	al Route Number,
<u>S</u>	ital or urs aft ral Dir led in								
	Hosp 24 hou Funel ted fil	Medical	(Check 2 Medical Examine	an: To the best of my knowle	and/or investigation, i	n my opinion, death occurred	at the time, date and p	place, and due to the o	ause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death of the conficient of the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but on the page of the page	ž	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of my		curred at the time, date and pla 9c. License number		use(s) and manner as I. Date signed (Month)	
	トメドグ) Ath	M.F		18111227		5/23/	
	()		30. Name and address of person who con		23a) (Type, Print)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carroll Ellen 10: 50AM 2010 Medical Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Northwes Kanda Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** -26-969 Months Days Hours Min Month, Day, Year 1 🗆 M 2 🕟 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Nes 2 □ No more 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2120 Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p Method of Disposition Surial 2 Cremation 3 Removal from State 12010 4 Donation 5 Other (Specify Si natural Funeral Servic 19/1ts Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition End-Stage Renal Disease h sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) After this certificate has been signed by the atter funeral director, page 2 should be detached for v in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specific Prot huspice Hospital 2 No Other: ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5/27/10 DU057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar N.S. Rajapakse, M.D

31. Date filed (Month, Day, Year)

2835 Smith AV-5-235- Baltimore, 21209

Anthony Cruckett 10-03795 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1 Decedent's Name (First Middle Last) Physician/ Month Day May 17, 2010 2152 hrs **Medical Examiner** MARK ANTHONY CROCKETT 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY Funeral Country) Months Davs Hours Director 1 X M 219-90-1031 1974 MD Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No 28a-f sho "natural", nr items 23a or 28a-f sho Examiner must be notified at nnce. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3626 GLENDALE AVE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces' White etc Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates: 3 Widowed 4 X Divorced 1 Yes 2 X No specify: Specify: BLACK 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) ges 1 and 2 should be filed within 72 h
of Health and Mental Hygiene.
If item 27 is marked nather 41——— Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 FURNITURE 12TH MOVER 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be VINCENT G. CROCKETT JOANN HOPKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3626 GLENDALE AVE., BALTIMORE, MD NIEKCO CROCKETT/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, ltimore, 3300 HOLLINS FERRY RD permit. Pages 1
Department of H
Important: If it crematory or other place) 1 Burial 2 Cremation 3 Removal from State 05/28/2010 LANSDOWNE, MD 21227 4 Donation 5 Other Specify ZION 22. Name and Address of Facility 21. Signature of Funeral Service Licenses WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD Approximate Interval death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and Medical Death a, Multiple (2) Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and trans Physician/Medical UNPENDED AMENDED the attending physician red for use as the burial -Division of Vital Records. P.O. Box 68760. IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ned by the detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot 1 Natural **FOUND** Pending 1 Yes 2 ✔ No 2 _ Accident May 17, 2010 2125 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 200 BLK of South Spring Court, Baltimore, MD within 24 hours at determined (Specify) Basketball Court 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 18, 2010 a 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Car1 Randall Cantrel1 2010 12:00PM June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. 7600 North Point Creek Road Edgemere 8. Date of Birth
(Month, Day, Year)
March 2.1953 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours Min Country) Kentucky 1 🙀 M 2 🗆 F Director 216-54-4974 57 Usual Residence of Decedent works permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Edgemere Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 United States 7600 North Point Creek Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by ☐ Yes 2 🔯 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Years Truck Driver Equipment Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alma Jane Wright Thurman Cantrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 North Point Creek Road Edgemere, MD 21219 (Sister) Betty Smith 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State any injury or Holly Hill Mem. Gdns. 6/5/2010 Middle River, MD 4 Donation 5 Other (Specify) ral Service Signature of Fun 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Marvland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequent Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N this certificate 1 Yes 2 No 24 hours after death.

Funeral Director: After this certificated filled in by the funeral director, Physician: 25. Was case referred to medica of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? Hospital or Attending Natural 5 Pending Division 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dundalk. AVE. DundalA. 31. Date filed (Month, Oay, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ 30^{Day} 201^Y0° 10:15 Alberta Carter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Balto If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Year) 9-17-1940 1 □ M 2**X** F Months Days Hours Min. 69 **Director** MD 216-34-8069 Usual Residence of Deceden 10a, State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 🔀 Yes 2 🗌 No MD na Balto 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21202 USA 1100 Somerset Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc "natural", or <u>ک</u> 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Completed Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Health Care Aide <u>llth grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gertrude Conigland Booker Boone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21244 3203 Southgreen Road Frances L. Boone-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6-4-2010 Carmel 21. Signature of Function Service Licensee 22. Name and Address of Facility March East F/H Balto, MD 21202 North Avenue 1101 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Day Pregnant at time of death 1 Yes 2 la 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No has 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: မ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F only one) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 U 1 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2010 Physician/ Month May Elsa Α Delgado-Mora 24 12:02 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 (Month, Day, Ye an 12, Puerto Rico Director 584-05-7594 65 Ĭ945 Jan Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director Puerto 1 Yes 2 X No Rico Arecibo 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8 Azalea Street 00612 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 X No ģ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 ¹∏ Yes 2 □ No Specify: Puerto Rican Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Luis Delgado Juanita Mora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Nelson Quinones - Son 2422 Valley Way Cheverly, MD 20785 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I 1 X Burial 2 Cremation 3 Removal from State Cementerio Nuevo 05-30-2010 injury Arecibo, Puerto Rico 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ocensee 169 San Felipe St. Arecibo, Puerto Rico 00612 art 🕽 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line mmediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 SE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Dav Pregnant at time of death 5 Other (specify) the 9 Unknown g Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury accurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring MD 20902 10301 Georgia Ave R. Boice 31. Date filed (Morith, Day, Year) State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2010 Year Dharia Kamalaben R. May 31 12:05 а. м Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Rockville Shady Grove Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Ye 1 DM 2 X F Hours 1915 Director India 213-96-4028 Jan. iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10a, State 10d. Inside City Limits 72 hours after death with the Maryland Director 1 🗌 Yes 2 🏝 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21808 Goshen School Rd. 20882 India 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian Indian 1 Yes 2X No Specify. "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Lalitaben Mody Chandulal Mody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21808 Goshen School Rd. Gaithersburg, MD 20882 Gopal Dharia 20a. Method of Disposition
1 ☐ Burial 2 XX cremation 3 ☐ Removal from State June Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01. Chesapeake Crematory Beltsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility Rapp Funeral & Cremation ture of Funeral Service Licensee 933 Gist Ave. Silver Spring, MD 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Aspiration Pneumonia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence on physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 □ Probably 4 □ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform page 2 After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital director. 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Yes ျှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; Natural 5 Pending iniury work?
1 Yes 2 No М Investigation Accident within 24 hours after death

To the Funeral Director:,

completed filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahryat Davari, M.D. 13113 Molecular Dr. Suite 206, Rockville, MD 20850

29d. Date signed (Month, Day, Year)

29c. License number

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of e

parte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10a-f Per FH G906 8/19/2010 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year June June Physician/ 2, 11:30 AM John Edward Denbow Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Year, July 4 1 Country) Pennsylvania 1 XM 2 🗆 Months Days Hours Min. Director 159-16-8041 96 1913 Usual Residence of Decedent 10b. County Beaver show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Beaver XX Yes 2 No or 28a-f Maryland Harford Bol Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 493 East Bend Ave. items 23a Funeral 15009 1546 Bentle 21015USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give Black, White, etc. 3 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education 5+ <u>College Professor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Howard Denbow Lutz Mary (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Sliwinski / Daughter 1546 Bentley Circle, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 4 Donation 5 Other (Specify) 6-5-10 Beaver, Pennsylvania Beaver Cemetery 21. Sign of Fun Service Dip 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abino 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA WITH SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine oue to for as a consequence of, cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours fiter death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by URINARY TRACT INFECTION, HYPERTENSION, Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ATRIAL FIBRILLATION, MYPOTHYROLDISM 24a. Was an autopsy performed? CORONARY ARTERY DISEASE Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Tes ည Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Director: After 1 Natural 5 Pending work? 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours -fter de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier ia ain 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION AVE, HAVRE DE GRACE, MD 21078 6225. strar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 Mildred M. Davis 30 6:27 РМ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Suburban Hospital <u>Bethesda</u> ${ t Montgomerv}$ Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min October 31 1 🗆 M 2 🗓 F Months Days Hours Washington, D.C. 87 **Director** 577-18-0045 Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Maryland Chevy Chase Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20815 3304 Jones Bridge Road United States death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Specify: White 3 XWidowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Me any injury or other traumatic event, the Me any injury or other traumatic event, the Me any injury or other traumatic event, the Me any injury or other traumatic event, the Me any injury or other traumatic event, the Me any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wilmer Dominic Russell Eva Marie Benson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia D. Roane/Daughter 7033 Boston Avenue, Rose Haven, Maryland 20714 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Arlington National 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 13, 2010 Arlington, Virginia Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. Haron 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Acute Respiratory Failure Medical Due to (or as a consequence of) Examiner Pulmonary Edema Sequentially list conditions, if any leading 1 immediate cause. Enter Underlying Examine Due to or as a consuluence of ng physician and as the burial-transit Cause (Disease or linjury Severe Mitral Regurgitation that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Congestive Heart Failure related to Mitral Regurgitation Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death ed by the a 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de Completed by the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 🗌 Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 XNo Other: 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/d investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number MD63285 June 1, 2010 20 ss of person who completed cause of death (Item 23a) (Type, Print) Eva Hausnerova, M.D. 5530 Wisconsin Avenue #515, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) **JUN 04** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

Jenise Daw		1- For State Registrar	5	tate of Maryla	•	artment o <i>rtificate o</i>		and Ment		Reg. No	20	10	17421
Physicia Medical Exami	an/ ner	1. Decedent's Nam Denise		fle,Last)					2. Date of Do Month	Day	Year		ne of Death
Medical Exam.	1101			on, give street and nu	ımber)		4b. City, Town	, or Location of	May 25,		c. County of		143 1113
		8614 Lugar	no Road			1	Randalls	town			Baltimore	County	
Funeral Director		5. Social Security N 214-64-		6. Sex	7. Age (In yrs. I	last birthday) 52 _{Yrs}	If Under 1 Months E		24Hrs. 8. Date of I		957		(State or Saryland
ž.		Usual Residence o	f Decedent 10b. County		10c City	. Town or Local	tion					10d I	nside City Limits
how a		MD		imore	1 1	ndallst							Yes 2 X No
farylan 28a-f s at one	Director	10e. Street and Nu	mber				10f. Zip Cod	е		10g. Cit	tizen of Wha	t Country?	
h the N 3a or		8614 L		Road			2113	3		U	SA		
Baltimore, MD 21215-0036 permit. Pages and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	uneral	Marital Status Never Marrie							n? (Specify Yes or f Puerto Rican, etc.)	No-	14. Race White,	American Inc etc.	dian, Black,
fter de:	╙	3 Widowed		1 Yes vorced If Yes, Give Yes or Dates:	2 X No	1	Yes 2 X	No specify:			Specify: W	hite	
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and 2 lealth 2 tem 2 traum		Rosalie 20a. Method of Disp		otner	20b.	Place of Dispos			Randalls		Location - C	-	
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nijury or other traumatic event, the Medical				n 3 Removal fr	om State	crematory or ot	her place)						
altir mit. P partme portai	-	4 X Donation 5 21 Signature of Fu			Directo:	r 22c	lame and Addr	ess of Facility	Board; 65		Balti	more !	Street
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Physician /M		23a. Part I. Enter the failure. List on	le disease, or ly one cause										roximate Interval ween Onset and Death
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	ji.	if any leading to im- cause. Enter Unde	rlying Cause	c.	consequence of	f)r-							
ed sit	Examine	(Disease or injury the events resulting in			consequence o	f):							
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and optetely filled in by the funeral director, page 2 should be detached for use as the burial - transit	<u>a</u>	XUNPENDED		d								+	
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Sox 6876 leath certificate e attending phy for use as the	sician/Medical	23b. Was decedent past 12 months		LIVE D	irth ant at time of de		tal death	3 Ectopic p	pregnancy		Month	Day	Year
Box e death c the atten	ysic	1 Yes 2 N	No 9 🗸 Uni			oti	her (Specify)						
hat the ed by t	by Phy	Part II. Other signif	ficant condit	ions contributing to	death but not re	esulting in the u	inderlying caus	e given in Part		_	use contribu		
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of Vital Records, g Physician: The law requir ther this certificate has been a neral director, page 2 should I	Completed	·								opsy formed?	pric		ndings available ion of cause of
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ttendi death. stor: /	atio	1 X Natural 2 Accident	5 Pend				1	Yes 2	io				
Division ospital or Attendin hours after death.	Certification:	3 Suicide		d not be rmined (Specify)	e of Injury - At ho	ome, farm, stree	et, factory, offic	e building, etc.	28f. Location or Town,		and Number	or Rural Rou	te Number, City
the Hospita hin 24 hours the Funeral		4 Homicide 29a. Certifier (Check only)		hysician: To the bes	t of my knowledg	ne death occur	red at the time	date and place	e and due to the cau	use(s) ar	nd manner as	stated	
To the Ho within 24 To the Fu completely	Medical			miner: On the basis of and manner st	of examination a								e(s)
F 5 F 5	ž	29b. Signature and	title of certifie		<u> </u>			nse number		1	Date signed		/, Year)
		La.	ral	- Mall	an		0.0	D.M.E.		May	y 26, 2010)	_
		 Name and address Carol Allan, 	· ·	who completed caus sistant Medical I	•	^{23a)} 111 Penn S	Street, Balti	more, MD 2	21201				
Sta	_	31. Date filed (Mont	h, Day, Year)	1 2010 32. P	gistrar's Signatu	ire A	ares						
Registi	e l		JUNU,	× ZUIUI LA	mission	.CI. 100	1						

OCME

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 3ď, May 2010 8:45 AM Frances G. Etter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care Chevy Chase Montgomery Chevy Chase 8. Date of Birth (Month, Day, Year) October 8, 1914 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 🕅 F 95 212-68-0608 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Chevy Chase Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 105 Primrose Street 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or items 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien. Important: If item 27 is marked other trainmails. Denta1 Hygientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nettie Mae Myers Oscar R. Goodhart ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Goodhart Etter / Son 381 Steven Way, Severna Park, Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 Burial 2 □ Cremation 3 □Removal from State Arlington National Cemetery 3, 2010 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungfal Service Licensee ROBERT A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 23a. Part / Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Failure to Thrive /Medical Due to (or as a consequence of) Examiner Possible Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Severe Peripheral Vascular Disease Division or Vital Records, P.O. Box 68760岁 Due to (or as a consequence of): attending physician Physician/Medical as the t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 🗓 No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? res 2 X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🔼 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours at To the Funeral C 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 2, 2010 D0054566

State Registrar DHMH 17 Rev 1/2001 9801 Georgia Avenue, #117, Silver Spring, Maryland 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sunitha Bhogavilli, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of I	Maryland					Mental Hy	/gier	ne 2010	7 171.26
			Registrar 1. Decedent's Name (First, Mid	idle, Las	st)		Cer	tificate o	f Deati	<u> </u>	2. Date of D	Reg.	No. U	3. Time of Death
	Physicia Medic				Robert I		ham, .				May 27		.010 Yea	
	Examir	er	4a. Facility Name (if not institute Shady Grove A					4b. City, Town	, or Location				4c. County of Do	
	Funeral Director		5. Social Security Number 214-34-6386	6. S	ex X M 2 \square F	Age (In yrs. las 71	t birthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs. Min.	8. Date of Bi	irth lav Yea	1938 Wa	Birthplace (State or Foreign Shington, D.C.
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. City,	Town or Loc	cation						10d. Inside City Limits
	Maryla 28a-f s stified	recto	Maryland Mont	gome	ery			Potomac						1 ☐ Yes 2 🛣 No
	with the s 23a or 2	by Funeral Director	10e. Street and Number 12209 Piney N	leet:	inghouse	Road		10f. Zip Cod	e 20854				Citizen of What	•
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Fun	11. Marital Status 1 ☐ Never Married 2 🏅 M 3 ☐ Widowed 4 ☐ Divord		12. Was Deceder Armed Force: 1 X Yes 2 If Yes, Give Year or Dates	s? No Viotne	"	Vas Decedent of Yes, specify C ☐ Yes 2 💆	uban, Mexi	can, Puerto	ecify Yes or No Rican, etc.))	Black, Wi	merican Indian, hite, etc. White
15-(72 hou n "nat Aedica	Completed	15. Dece (Specify only hi	ghest gra	ade completed)		(Give k	ent's Usual Oci ind of work do NOT use retir	ne during n	nost of work	king	16b	. Kind of Busine	ss Industry
212	within /giene. ner tha t, the l	S	Elementary/Seconday (0-12		College (1-4 c	or 5+)	Own					s	ervice	Station
Maryland 21215-0036	ld be filed Mental Hy arked ott	To Be	17. Father's Name (First, Middl Robert L. I		nam						ne (First, Middle Dillor		en Surname)	
, Mar	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relation Phyllis A. Eas										or Town, State,	Zip Code) Maryland 2085
Baltimore,	Page 1 ament of H tant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	r (Specif	y)	cer	netery, crem	sition (Name of hatory or other p k Cemet	ery	Jun 20	e 3,	1	Location - City	n, D.C.
Balt	Depart Depart Impor any in		21. Signature of Funeral Service	e Licens	see	M0019	8 R6	Name and Ad bert A. 57 Wisc	Pumpl onsir	nrey 1	Funeral Bethe	Hoi sda	me/Bethe	esda-Chevy hase, Inc. 114-3501
	Physician/		23a. Part 1 Inter the disease shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	or comp st only o	Acute	ine. Myoca	rdial	r the mode of c	lying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Y	Examiner			ſ		s a consequer coscler		Coronar	y Art	ery D	isease			Years
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13.	ate be executed bhysician and the burial-transit	al Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	1	C. Due to (or a	as a conseque	nce of):							
3760	ate ohy: the	A edical	,	_	d									
. Box 68	Attending Physician: The law requires that the death certifics r death. sctor: After this certificate has been signed by the attending p sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as it.	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			h 2 ☐ Fetalo tattime of dea	death 3	Ectopic pregn Other (specify					23d. Date of o	delivery Day Year
ds, P.O.	luires that the in signed by t uld be detach	ed by Pr	Part II. Other significant cond	itions co	ontributing to death	n but not result	ting in the ur	nderlying cause	given in P	art I.				to the cause of death? Probably 4 🖺 Unknown
Division of Vital Records,	sician: The law require certificate has been si irector, page 2 should b	Somplet									24a. Was auto perf 1 Yes	nsv	24b. Were a prior to death	autopsy findings available to completion of cause of ? //es 2 No
ita	Physician: this certificated director, I	Be	25. Was case referred to medic examiner?		Hospital:)thor:	eath (Chec	k only one)			
of V	Phys er this eral dir	e: To	1 Yes 2 No 27. Manner of Death		1 Inp	atient 2 🔀 El	8b. Time of	28c. In	4 ⊔ jury at	Nursing Ho	ome 5 Res		6 Other (Sp	ecify)
on	ttending I death. stor; After the funer	ficat	1 Natural 5 Per 2 Accident Inve 3 Suicide 6 Cou	stigation		Day, Year)	injury		ork? ☐ Yes 2	□No				
Divisi	ital or Atten ins after deat al Director; led in by the	al Certificate:	4 Homicide dete	rmined	28e. Place of I building,	etc. (Specify)	<u> </u>				City or To	wn, Sta	ite)	Rural Route Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completed filled in by	Medical	(Check 2 ☐ Medica only one) 3 ☐ Certify	ng Nurs	sician: To the best ner: On the basis o se Practioner: To the	f examination a	nd/or investi	gation, in my op eath occurred a	inion, death t the time, c	occurred a late and place	t the time, date	and pla	ce, and due to th	e cause(s) and manner stated
	With World		29b. Signature and title of certi	fier	2)	Z	2		nse numbe	025			Date signed (Mol A -(2	7 2010
	25x,		30. Name and address of persons Jonathan Wenk	, M.	D. 9901	Medic	3a) (Type, Pi al Cer	^{int)} ter Dri	ve, F	lockvi	lle, Ma	ary]	Land 20	850
	Stat Registra	-	31. Date filed (Month, , Qay,, Yea	1 0	32. Regis	trar's Signatur								
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, 1 M 2 F Months Days Hours Min. Yrs. Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 M No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 2 **N**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. it of Health and Mental Hygiene.
If item 27 is marked other than "natu or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) pernit. Page 1 and 2 st Der artment of Health a Important: If item 27 is any injury or other trai once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Addr chape. 23a. For 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Physician/ Cervical Cana disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24 hours after death.

Funeral Director. After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Hospital Other: ဂ္ 1 Yes 2 No Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2 3, 2010 R149194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Charles 21204 0 Towison, Gran 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 31^{Day} Physician/ May 2010 3:20 Рм Edward Fernandes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard 9613 Longview Drive Ellicott City Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F Month, Day, Year December 17 Hours 038-12-3811 84 Yrs 1926 Rhode Island **Director** Usual Residence of Decedent or 28a-f show notified at filed within 72 hours after death with the Maryland all Hygiene.
d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event, the 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 United States 3700 North Capitol Street, NW, #1003 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 \(\subseteq \) No \(1955-\) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No. Specify: Specify: White Completed 3 Nidowed 4 Divorced 1974 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Seconday (0-12) College (1-4 or 5+) Navy Airplane Mechanic 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) i. Page 1 and 2 should be file trent of Health and Mental Ε rtant: If item 27 is marked of jury or other traumatic ever ၉ Marion Durand Albert Fernandes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9613 Longview Drive, Ellicott City, Maryland 21042 Edward Fernandes / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗔 Removal from State August 2010 Department o Important: If any injury or once. Arlington, Virginia Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Robert A. Fumphrey Funeral Home/Bethesda- Chevy Chase, Inc. Lette Baron wo M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SMALL CELL NEZZS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 🔲 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 🛭 Other (Specify) SONS HOME 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, noleted filled in by 4 Homicide City or Town, State) Medical 29a. Certifier 1 Decrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29d. Date signed (Month, Day, Year)

UX,

Registrar

6701 N CHARLES ST, SWITE 4105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DANIEUE DOBERMAN, MO

JUN 04

31. Date filed (Month, Day, Year)

MAY 31, 2010

BALTIMONEIMO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Ruth Fegley May 1:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Baltimore Towson 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🖾 F (Month, Day, Oct 21, Months Days Min. Director 170-20-8900 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimoe 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6000 Ivydene Terrace; Apt E-I 21209 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72; in and Mental Hygiene.
7 is marked other than "r Social Security Elementary/Seconday (0-12) College (1-4 or 5+) social worker Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Thomas Fegley Ellen West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Woodland Court; Glassboro, New Jersey 08028 John Gorgonson/nephew 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from Stat 4 ☑ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Ronald S. Wa ²² Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street rector Baltimore, Maryland 21201 23a. Pirt 1. Enter the discase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedian Cause (Final disease or condition resulting in death) Physician/) ebilit Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of Exam that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 🗌 Yes 2 🗌 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛛 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗆 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Box 68760 P.O. To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sion Records, of Vital within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral Division

Baltimore, Maryland 21215-0036

State Registrar (Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day

28569

32. R gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

Grant

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Touson,

12149194

MD

29d. Date signed (Month, Day, Year)

may 27, 2010

10-04088	0-	Please T									ible.	0 174	30
Roland Anthony		1- For State	state of i	viaryiano	l / Departr <i>Certifi</i>		г пеашта f Death	na ivieni	tai nygier	Reg.	L ∪ I	0 1 1 4	00
Physici	an/	Registrar 1. Decedent's Name (First, Mic							Mor	e of Death	Day Year	3. Time of Death	h
Medical Exam	ner	Roland Anth			r)	1.	4b. City, Town,	or Location o	May	29, 201	4c. County of D	0913 hrs	
		640 South Ponca St	_		• 7		Baltimore	0. 2002000	, 500			N/A	
Funeral		5. Social Security Number	6. Sex	7. A	ge (In yrs. last b	oirthday)	If Under 1 Ye			ate of Birth	(MM/DD/YYYY) 9	. Birthplace (State or Country)	Foreign
Director		UNK.	1 X M	2_F		70 Yrs	. Iviorius De	ays Flours	Fe	eb 10	, 1940	Maryland	
япу		Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. City, Tov	vn or Locat	ion					10d. Inside City	Limits
and show a	'n	Maryland	N/A		В	altim	ore					1 X Yes 2	No
ne Maryland or 28a-f show any fied at once.	rect	10e. Street and Number	-				10f. Zip Code			10g	. Citizen of What (Country?	
death with the Maryland or items 23s or 28s-f sho must be notified at once	Funeral Director	640 Ponca Str		Was Deceder	at Everia II C	42 10/0		224	is? / Esseifu V	on or No	USA	merican Indian, Black	
eath wi	ıner	1 Never Married 2	Married	Armed Forces			s Decedent of H es, specify Cub				White, et		1
after de	by Fu	3 Widowed 4	Divorced If Yes		2 [X] NO	1	Yes 2 X	lo specify:			Specify: W	hite	
hours 'natur Exami	ed t	15. Decedent's Education (S	pecify only hig	ghest grade co			t's Usual Occup ost of working li			ne 11	6b. Kind of Busine	ess/Industry	
36 hin 72 e. than '	Completed	Elementary/Secondary (0-1.	2)	College (1-4 or	(5+)	Ace 1	Binding	Compa	inv		Clo-	thing	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Midd	le, Last)		1				's Name (First,	Middle, Ma	iden Surname)	ctittig	
121 d be fi fental	Be	Johnny Gossma		Drint \	14	Ob Mailine	Address (Sta		Imma Mee		S er, City or Town, S	State Zin Code)	
AD 2 2 shoul 1 and N 27 is m	P _C	Lucille D. B		•							arrows, 5		
Ge, North Health Fitem		20a. Method of Disposition				e of Dispos	ition (Name of o	emetery,	Date	12	20c. Location - Cit	y or Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If 'item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumstic event, the Medical Examiner must be notified at once.	П	1 Burial 2 XCremati 4 Donation 5 Other	Specify:		Metro) Čre	natory		06/03/			ce, Maryla	
Salti ermit. Departr mport njury	j	21. Signature of Funeral Servi	ce Chensee	Thomas	Gregor	22. N	lame and Addre €Mation	ss of Facility Socie	ty Of	Jarvla	and. Inc.	land 21228	
Physician		23a. Part I. Enter the disease,	or complicate	ons that cause	d the death. Do	not enter the	Preder	ICK K g, such as ca	oad Ball ardiac or respira	timor atory arrest	ce, Mary	Land 21228 Approximate In	nterval
/Medical		failure. List only one cause Immediate Cause (Final disea	A di-		Cardiovaso	cular Dis	ease					Between Onse Death	et and
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be exec	dica	UNPENDED	П АМ	ENDED									
Division of Vital Records, P.O. Box 68760, at or Attending Physician: The law requires that the death certificate be executed rs after driving and the remaining physician and led in by the funeral director, page 2 should be detached for use as the burial - transit	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in		Live birth	ome of pregnand	_	tal death 3	Ectopic	pregnancy		23d. Date of deli Month	very Day Yea	ar
X 68 th cert ttendir r use a	sicia	past 12 months?	Inknown a	Pregnant a	at time of death		ner (Specify)					•	
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eco he law ate has age 2 sl	dwc	4								performe	ed? deat	h?	No
al R ian: T certifica ctor, pa	a l	25. Was case referred to medi examiner?					26.Pła		(Check only one				
F Vit Physic r this c	To B	1 ✓ Yes 2 No	Hospit	тпрац		Outpatient		Other; jury at Work?	Nursing Home		esidence 6 🗸 0	ther: Scene	
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r Atter ter dea irector n by th	ficat		vestigation build not be	28e. Place of I	Injury - At home,	farm, stree	et, factory, office	building, etc				r Rural Route Number	r, City
Div pital o ours af teral D	Certification:	4 Homicide		(Specify)					or	Town, Stat	ie)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		CHOCK ONLY									s) and manner as d place, and due t		
To t with To tl	Medical	29b. Signature and title of cert	and	manner stated				nse number	-			(Month, Day, Year)	
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1		30. Name and address of pers				•	A Daliber -	MD 040	01				_
1		Ling Li, MD Assis	tant Medic	aı ⊏xamıne	er 111 Pe	nn otree	ii, baillmore	, IVIU 2720	UI				

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State 31. Date filed (Month, Day, Year) jistrar

llen Green-Pres	со	State of Maryland /					Aipie. S. I	0 143
		I- For State Registrar	•	te of Death			eg. No.	
Physicia Medical Examir	n/	Decedent's Name (First, Middle,Last) Ellen		Green-Pre	sco	2. Date of Deat Month May 26, 2	Day Year 010	3. Time of Death 1109 hrs
		4a. Facility Name (if not institution, give street and number) 3711 Edmondson Avenue		4b. City, Town, o	r Location of Deat	h	4c. County of D	eath
Funeral			(In yrs. last birth	day) If Under 1 Ye Months Da				Birthplace (State or Foreign Country)
Director	-	218-60-4715 1 M 2XF Usual Residence of Decedent	57	Yrs.		03 2	5 53	MD
v a0y	-		10c. City, Town o					10d. Inside City Limits
Maryland 28a-f show	힕	MD NA 10e. Street and Number	Ba	ltimore 10f. Zip Code		11	Og. Citizen of What	1 Yes 2 No
he Mar 1 or 28	ě١	3711 Edmondson Ave			21229	ľ	U.S.	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must he notified at once	— L	11. Marital Status 1 Never Married 2 Married Armed Forces?	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba			14. Race - A White, et	merican Indian, Black,
rer deat			X No	1 Yes 2 X N		,	Specify:	Black
ours aft	ğ P	or Dates: 15. Decedent's Education (Specify only highest grade com	pleted) 16a. D	Decedent's Usual Occupa	ation (Give kind of		16b. Kind of Busine	ess/Industry
74 3 🖃	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+)	Unemploy		,	Unem	ployed
5-0036 led within 72 hours tygiene. other thao "natur	틩	17. Father's Name (First, Middle, Last)		0		e (First, Middle, I	Maiden Surname)	
21 be fi rrked	o Be	James Green 19a. Informant's Name/Relationship (Type, Print)	19h	. Mailing Address (Stre		a Keith		State Zin Code)
MD 2 12 shoul th and N 127 is m	ř	Keisha Presco-Daughte	54	10 Lafaye				
and and lealt tra	Ī	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Sta	20b. Place of	Disposition (Name of cory or other place)	emetery,	Date	20c. Location - Cit	ty or Town, State
Baltimore, permit. Pages la Department of He Important: If its injury or other t		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	On-	-Site		8/2010	Baltim	ore, Md
Bal permir Depar Impo	1	21. Signature of Funeral Service License	Jes	22. Name and Addres March F.	H West	e, Balt	imore,	Md 21215
Physician Medical		23a. art I. Enter the disease, or complications that caused lure. List only one cause on each line.		tenter the mode of dying	, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
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Box 68760, e death certificate be the attending physic ed for use as the but	Physician/Me	past 12 months?	time of death 5					
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n of ding Ph. After tl		27. Manner of Death 28a. Date of Inju (Month, Day,Yo	'y 28b. Т эаг)		ury at Work? Yes 2 No	28d. Describe	how injury occurred	
Sion Attencer death rector:	icati	2 Accident Investigation 28e. Place of Ini	ury - At home, far	rm, street, factory, office		28f. Location (Street and Number of	or Rural Route Number, City
Division pital or Attent ours after death filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)				or Town, S	State)	
Division of Vital Records, P.O. Box 68760, vithin 14 hours after death. Cartificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burity.	Medical C	29a. Certifier (Check only 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner and manner stated.						
7. W. W. T. O. O. O. O. O. O. O. O. O. O. O. O. O.	Me	29b/ Signature and title of certifier			ise number			(Month, Day, Year)
		(Coklaremy)	anth (line on the	0.0	.M.E.		May 27, 2010	
2		30. Name and address of person who completed cause of di Laron Locke MD. Assistant Medical Exa		Penn Street, Balt	imore, MD 21	201		

Registrar

			Please	Type or Print in I	Black Indo	elible Ink. Ensure 04,6/10/201,WS ment of Health and	All Copies A	re Legible.			
		•	For State Registrar	State of Marylan		icate of Death		Reg. No. 2010 17432			
	Physicia Medic		1. Decedent's Name (First, Middle, Las	t)	rail		2. Date of Death	Day 3, Time of Death 9, A, M			
)	Examin	er	4a, Facility Name (if pot institution, give	d Living Fa	cility	City, Town, or Location of Death Bathmo Under 1 Year 1 If Under 24 Hrs	rore Na				
	Funeral Director		5. Social Security Number 3.12-30-6063 Usual Residence of Decedent	7. Age Jin yrs. la		Under 1 Year If Under 24 Hrs onths Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country) Naryland			
	Varyland 18a-f show utified at	Director	10a. State 10b. County	Q 10c. Cit	y, Town or Location	timore.		10d. Inside City Limits 1 ⊡rYes 2 □ No			
	with the I		10e. Street and Number	Nico RN	o d 1	0f. Zip Code 21209	10g.	Citizen of What Country?			
920	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Decedent of Hispanic Origin? (S ₁ s, specify Cuban, Mexican, Puert Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:			
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1212	ed within Hygiene. o ther tha ent, the N	ادہ ا	Elementary/Seconday (0-12) 17. Father's Name (First, Middle, Last)	College (1-4 or 5+)		Nursing	me (First, Middle, Maid	Facilities			
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	d 2 shou alth and 1 27 is m er traum		19a. Informant's Nam / Relationship (T)	pe, Print) (SON)	19b. Mailing A	ddress (Street and Number or Ru Tuiunga- Av	ral Route Number, City	vor Town, State, Zip Code) 91604 tudio City, CA			
=			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Place of Disposition remetery, cremato	n (Name of ry or other place)	Date 20c	Location - City or Town, State			
Baltii	permit. Page Department of Important: If any injury or once.		21. Six ature Fun ral Service Licens	4 11 00	22-13	me and Address of Facility	SS Funero	ul Home, C.A.			
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused the death	h. Do not enter th	e mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between			
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Box 68760	to the hospital or Attending Physician; The law requires that the death certificate be ex- within 24 burs after death. To the termeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c	aldeath 3 🗌 Ec	topic pregnancy her (specify)		23d. Date of delivery Month Day Year			
P.O.	es tnat tn igned by be detac	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the unde	rlying cause given in Part ł.		co use contribute to the cause of death?			
ords	w required is been so should	Completed					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
I Rec	sician; The law certificate has rector, page 2:		25. Was case referred to medical			26. Place of Death (Che	performed 1 ☐ Yes 2 🔀	? death?			
f Vita	nysicia this cert al direct	To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital:		□ DOA Other: 4 □ Nursing H	lome 5 Residence				
o uo	ending reath.	Certificate:	1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? M 1 Yes 2 No	28d. Describe how in	njury occurred			
Division of Vital Records,	to the hospital or Attending Prystoan; the law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Specify)		City or Town, St				
	ne nosp in 24 hou he Funei ipleted fil	Medical	(Check 2 Medical Exami	ner: On the basis of examination	n and/or investigati	red at the time, date and place, a ion, in my opinion, death occurred n occurred at the time, date and pla	at the time, date and pla	ace, and due to the cause(s) and manner stated.			
	With Com		29b. Signature and title of certifier	Brow AM	,	29c. License number Dov 259	95 0	Date signed (Month, Day, Year)			
	4		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print)	WYMAN PA	RK DRIVE	16.03.2010 BACTIMORE MD			
	Stat Registra		31. Date filed (Month, Day, Year) JUN 0 4 20	32. Registrar's Signat	J. Son	No		2/2//			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 30 2010 MAY 5:05 P M LOUISE COLVIN GROVES Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min Nov. 3 Year)920 1 M 2 X F 89 Virginia 578-18-9656 Director Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20851 United States 316 Gruenther Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2xxxNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANo Specify: Specify: White 3 ₺ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Grace Elizabeth Darnell Harry Walter Colvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Farragut Ave. Rockville, Maryland 20851 Larry E. Groves (son) 20a. Method of Disposition 20b. Place of Disposition (Name of June Date 3. 20c. Location - City or Town, State cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2XXCremation 3 Removal from State 2010 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury the attending physician and the for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No
9 Unknown sate has been signed by the atte page 2 should be detached for Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed' this certificate 1 Yes 2 No 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🔀 No Certificate: To 1 Yes ER/Outpatient 3 DOA 1 😾 Inpatient 2 🗌 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident work?
1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certiff 29c. License number 29d. Date signed (Month, Day, Year) D 40389 06012010 NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BETHESDA MD 20889-5600 CATHERINE F. DECKER

DHMH 17 Rev 7/2009

State Registrar egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g904 6-4-10 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 12-45AM Marjorie Giles 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOME Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, **Funeral** 1 □ M 2 F Hours Months Days Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Tr. Predicti Eng. ing. in this of any injury or other traumatic event, Tr. Predicti Eng. ing. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 124 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ပ Terson BP 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number lliamona 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ourdiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** VOSCIE disease or condition resulting in death) /Medical Due to (or consequence of) Examiner Sequentially list conditions, Examiner i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy performed? death? 2 No 1 ☐ Yes 2 No 1 □ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 □No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD 32. Registrar's Si 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year Month **Physician** 5 2010 12:02AM Greenwood neresa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mercy Medical

5. Social Security Number 6. S Baltimore Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Bay Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

TNT **Funeral** Hours 1 □ M 2 🔀 F IN 306-34-0009 80 Yrs Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Marical Examiner must be notified at once. 1 ☐ Yes 2 ☑ No Director Owings Mills Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 USA 4721 Clairlee Drive. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married African-American altimore, Maryland 21215-0036 1 ☐ Yes 2 🗐 No Specify: Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Goldblatts Dept. Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Spigner William Day ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4721 Clairlee Drive, Owings Mills,MD 21117 Marilyn C. Hines/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date t☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) Oak Hill Cemetery 6-5-2010 Gary, IN 22. Name and Address of Facility eture of Funeral Service Licensee Wylie Funeral Home P.A. of Baito. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical to (or s a consequence of): Examiner Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician is be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, ≥ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown on the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No Division of Vital Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes Impatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the l within 2 To the l 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9749801 5/29/2010 30. Name and who completed cause of death (Item 23a) (Type, Print) ess of persor Baltmore 3 reene 32 Registrar's Signature 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Manth T.05PM Thomas Gresham 4b. City, Town, or Location of Death 4c. County of Death GLEN BUE If Under Year If Under 24 Hrs. 8. Date of Birth 6. Sex g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1 ⊋ M 2 □ F Months Days Hours (Month, Day, Year) Country) 89 Dec Virái 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arudel Pasadena 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 21122 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 ☐ No Specify Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) of Defence 18. Mother's Name (First, Middle, Maiden Surname) Wright

Approximate Interval Between Onset and Death

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

DOID

20161

mi

1 ☐ Yes 2 ☐ No

Year

Month

1. Decedent's Name (First, Middle, Last) Physician/ Hugh Medical 4a. Facility Name (if not institution, give street and number) Examiner BALTIMBRE WASHINGTON MEDICAL 5. Social Security Number Funeral 225-01-6838 Director Usual Residence of Decedent 28a-f show 10a State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at death with the Maryland Director Maryland 10e. Street and Number Funeral 8348 Sail Circle 11. Marital Status 1 Never Married 2 X Married Completed by 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 3 Widowed 4 Divorced d Mental Hygiene. marked other than Elementary/Seconday (0-12) 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) ပ Edgar Gertrude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Margaret L. Gresham Sail Circle Pasadena MD 21122 spouse 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 6/2/10 Baltimore Maryland 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Part 1. Enter the disease, or complication ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. shock, or heart failure. List only one Immediate Cause (Final Pnysiciani ENGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy cate has been signed by the atter, page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an After this certificate has autopsy performed 2 No Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital 2 No ပ္ 1 Tyes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

• Funeral Director: After neted filled in by the fur 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) alli leted cause of death (Item 23a) (Type, Print)

State Registrar

mame and address of person who con

evive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			partment of Health and Nertificate of Death	· -	ene 0 0	17437					
Physicia		1. Decedent's Name (First, Middle, Last) Henry Goping		3. Time of Death 2:30 PM							
Medi Exami		4a. Facility Name (if not institution, give street and number) 15245 Dufief Drive	4b. City, Town, or Location of Death Gaithersburg	May 30,	4c. County of Death						
Funeral Director		5. Social Security Number $\begin{bmatrix} 6. \text{ Sex} \\ 1 \text{ $\stackrel{\frown}{M}$ M 2 \square } \end{bmatrix}$ 7. Age (In yrs. last birthday Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Y January 3,	9. Birti 1921 Ind	hplace (State or Foreign intry) onesia					
aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Unity Maryland Montgomery	ocation Gaithersburg			10d. Inside City Limits 1 ☐ Yes 2 🏅 No					
with the M s 23a or 28 ust be not	Funeral Dir	10e. Street and Number 15245 Dufief Drive	10f. Zip Code 20878		ng. Citizen of What Co United Sta	*					
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at	ed by Fun	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spulf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🗶 No Specify:	Black, White	4. Race - American Indian, Black, White, etc. pecify: Asian						
Baltimore, Maryland 21215-0036 oernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. "Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examprise."	Completed										
yland d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Unavailable	18. Mother's Nam Unavai	e (First, Middle, Maiden Sumame) lable							
Mary, Mary d 2 should salth and N 27 is maler trauma	1	19a. Informant's Name/Relationship (Type, Print) Gertrud Goping / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15245 Dufief Drive, Gaithersburg, Maryland 20878									
Limore Page 1 arment of H lant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetery, cr	ossition (Name of ematory or other place) Crematorium, Inc. 201	۷, ۱,	Oc. Location - City or Bethesda,						
Balt permit Depart Import any inj			22. Name and Address of Facility. Obert A. Pumphrey Fune: 00 West Montgomery Ave			nd 20850-2805					
Physician Medical		23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cerebrovascular Accident Approximate Interval Between Street and Death 20 September 20 Septembe									
Examiner		resulting in death) Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Dementia C. Due to (or as a consequence of): Dementia Due to (or as a consequence of): Dementia Due to (or as a consequence of):									
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of death 1 Live Birth 2 Fetal death 3 Ectopic pregnancy Month Month 2 Month Mo									
ords, P.O. Be requires that the de- been signed by the s should be detached	ğ										
Record The law requeste has been page 2 should have been should be should b	Completed	24a. Was an 24b. Were a autopsy prior to performed? 1									
f Vital Physician this certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		ome 5 X Residen	ace 6 🗆 Other (Spec	ify)					
hivision of Vital Rec or Attending Physician: The la after death, Director: After this certificate ha In by the funeral director, page	Certificate:	27. Manner of Death 1 A Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred							
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the tu		4 Homicide determined 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street and Number or R City or Town, State)									
o the Hos ithin 24 h o the Fun ompleted	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the basis of my knowledge, deat (check only one) 3 ☐ Certifying Physician: To the basis of examination and/or involved only one) 29b. Signature and title of certifier	estigation, in my opinion, death occurred a	t the time, date and ce, and due to the c	place, and due to the	cause(s) and manner stated. stated.					
F 3 F 8		· Guya Wills	D0040201		June 1, 20						
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Farzad Assar, M.D. 1 Executive Park Court, Germantown, Maryland 20874 31. Date filed (Month, Day, Year) 32. Refistrar's Signature									
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Refistrar's Signature	hadel								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician /Medical Town, or Location of Death Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/15/1946 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF 63 Yrs **Director** 167-40-7190 Hanover, PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at PA York Hanover 1 Yes 2 XNo Directo 10f. Zip-Code 10e. Street and Number 10g. Citizen of What Country? death with 45 Moore Drive 17331 USA Funeral Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 🎇 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kale Agnes Livelsberger မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau once. James B. Grove 45 Moore Drive, Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cremation Direct Svc. 5/20/2010 York, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Licensee 22. Name and Address of Facility 311 Broadway, Panebaker F.H. Hanover, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed use as the burial-trar (or as a consequence of) attending physician for use as the buri Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 9 Unknown 5 Other (specify) 2 **V** No Division of Vital Records, P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has 1 Yes 2 No this certificate completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\tag{Nursing Home} \) 5 \(\tag{Residence} \) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attending P s after death. I Director: After t (Month, Day 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be determined 4 - Homicide 24 hours a Hospita 29a. Certifier (check only 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 1 vithin 2 To the 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) МO RES-000 completed cause of death (Item 23a) (Type, Print)

6 V

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32.

Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#23a,pt1,G906,8/9/2010,WS,perPHYS
State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GORXIEVA 2090 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springhouse of Pikesville Baltimore Pikesville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 🗆 M 2 🖪 Hours Feb. 6, Yell 919 Germany 223-86-8506 91 **Director** Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exam<u>iner must be notified at</u> Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director VA Clarke Boyce 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22620 330 Burch Lane United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျှ unknown Pemskover Zimmerman Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Petja G. Scheele, Daughter 420 Euclid Avenue, Sandpoint, ID 83864 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 06/02/2010 Orlando, Florida 4 Donation To Other (Specify) Orlando Crematory 21. Signature of Furer 15 rvice Licens MedCure, Inc. M01113 22. Name and Address of Facility P.O. Box 55730, Portland, Oregon 97238 23a. Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. **Atherosclerotic Heart Disease** Approximate Interval Between Onset and Death Immediate Cause (Final Smsum Physiciani SIMEN & month disease or condition) Medical resulting in death) Due to (as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or se a noneequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth 2 Li retail 4 Pregnant at time of death in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 1 No 2 No 1 🗌 Yes Yes funeral director. Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death. Funeral Director: A Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) R08885Z 2010 rson who completed cause of death (Item 23a) (Type, Print) Name and address of Aumur #203 / Southure 835 SMITH DANSSUC. Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last). Anna Harmon 2. Date of Death Physician/ 671/10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Stella Maris Hospice Timonioum 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 307–22–8274 **Funeral** 1 □ M 2 🔀 F 86 Months Hours 1/20/1924 Director Usual Residence of Decedent or items 23a or 28a-f show 10b. County 10a. State 72 hours after death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director MD Harford Fallston 10e. Street and Number 1513 Ryan Rd 10f. Zip Code Funeral 21047-1634 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No þ 1 Never Married 2X Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give than "natural", 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within 72 vf Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Be 17. Father's Name (First, Middle, Last) ဂ္ Walter Magolske Rose Fratus . Informant's Name/Belationship (Type, Print) / Richard Hershberger / Baltimore, Important; If item 20a. Method of Disposition permit. Page 1 a Department of h 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Chapel Hill Mem. Gardens 6/4/10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State JUNE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility harles L. Stevens 1501 E. Fort Ave, . Signature of Funeral Service Licensee Victor P. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) DEMENTIA Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be execute signed by the attending physician and dbe detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed?
Yes 2 X No After this certificate has funeral director, page 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 1 X Natural injury 5 Pending n 24 hours after death.

le Funeral Director: A pleted filled in by the fu Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier (Check the within To the 29b. Signature and title of certifie

12:01am ^M 4c. County of Death Baltimore 9. Birthplace (State or Foreign Indiana 10d. Inside City Limits 1 ☐ Yes 2 1 No 10g. Citizen of What Country? USA 14. Race - American Indian Black, White, etc. white 16b. Kind of Business Industry Factory 18. Mother's Name (First, Middle, Maiden Surname) 19b Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 1513 Ryan Rd, Fallston MD 21047–1634 20c. Location - City or Town, State Osceola. Indiana Funeral Home, Inc. Baltimore MD 21230 Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continues Practioner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continues Practioner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continues Practioner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continues Practioner To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continues Practioner To the basis of examination and/or investigation, in my opinion, death occurred at the time. 29d. Date signed (Month. Day. Year) and address of person who completed cause of death (Item 23a) (Type, Print) JEMNIFER HAUF, /CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Régistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical hurman 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death timore monly 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) If Under 24 Hrs Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F 69 Months Country) Yrs Director Jacch 23.199 Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Army
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 27 is marked other than "natur traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (T pe, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) shena other 20a. Method of Disposition 20b. Place of Disposition (Name of Date wwk 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Piner | Service Licen 18434 22. Name and Address of Facility 12 32 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1 , or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Secuentially list o in this is Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician by Physician/Medical 2010 requires that the death certificate be Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death should be detached Unknown signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an HYDER the Hospital or Attending Physician: The law page 2 s autopsy performed has After this certificate Yes 2 🗆 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) THURMAN examiner? Hospital: ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death **To the Funeral Director**: A Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifie 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe Qis-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY ROAD M.D.ERNESTINE WRIGHT, 31. Date filed (Month, Day, Year) 32. Registr 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 27, 2010 7:45 AM Harrison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Crofton Convalescent Center Crofton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Months Davs Hours April 28, 1913 Country 402-05-7014 KY **Director** 97 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Anne Arundel Odenton 1 Tes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1522 Star Stella Drive 21113 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Dccupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance US Government 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nannie Winfrey Thomas Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1522 Star Stella Drive, Odenton, MD 21113 Joann Harrison, Daughter item 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If its
any injury or of 1 X Burial 2 Cremation 3 Removal from State Parksley Cemetery 05/31/2010 Parksley, Virginia 4 Donation 5 Other (Specify) of Figural Service Licensee Thornton Funeral Home M01113 22. Name and Address of Facility Signatu 24183 Chadbourne Street, Parksley, VA 23421 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Dnset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) RALLO Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that intitated as a conditional sequences) Examiner attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 2 🗌 No 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛣 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Acertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 10 30. Name and address of person wi completed cause of death (Item 23a) (Type, Print) an D_{\star} 31. Date filed (Month, Day, Year) Pegistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 0708 rian Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Columbia County Coneval 1-10 Warg 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birtl **Funeral** Months Hours (Month, Day, Country) 81 359-20-3522 Director Dec Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Howard Woodbine 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral items 23a 16235 Carrs Mill Road 21797 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ö þ Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐XNo Specify: If Yes Give 'natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ပ Carl Bruckner Lucille Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16235 Carrs Mill Rd., Woodbine, MD 21797 Mr. Richard Ingels (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State All County Cremation 6-4-10 1 Burial 2 KCremation 3 Removal from State 4 Donation 5 DOther (Specify) Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Parge tredreje typingle P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ dronamy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death ed by the a 23e. Did tobacco use contribute to the cause of death? signed I ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed' certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 410 ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and Me of certifier 29d. Date signed (Month, Day, Year) 1142892

Registrar

DHMH 17 Rev 7/2009

State

brive #310

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Engistrar's Signature

amend State of Maryland Bepartment of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Luther Jones Jr. 3: 05 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Randallstown Baltimore Season's Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1**火** M 2 □ F Days Months Hours (Month, Day, Year) Director 249-34-3621 80 Usual Residence of Decedent 3a or 28a-f show t be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itemated other than "natural" or itemated. 10a, State 10b, County 10c. City, Town or Location 10d Inside City Limits Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 1819 Penrose Ave U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black 3√ Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Long Shoreman 12th grade Crane Operator na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mamie Fulmore <u>Luther Jones Sr.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penrose Ave, Baltimore, Md 21223 Luther Jones Jr.-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 ロ Donation 5 □ Other (Specify) King Memorial Park 6/7/2010 Woodlawn, Md Signatur 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, uneral Service Licensee 21215 Pal 1. Enter the dise se, or complications that cause shock, or heart failt re List only one cause on each line. e, or complications that caused the ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Return Interval Between Onset and Death Immediate Cause (Final End-Stage Renal Physician/ Disease disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 10 Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other Specify 705pile 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, des 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 115 Kajapakal Mid 5/28/10 20057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-235, Baltimore, MD. 21209 N'S Rajapakse, MID 2835 Smith AV. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Sert 3:13 PM June 4010 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner 4c. County of Death Himora Sevor Hospita If Under 1 Year If Under 24 Hrs. 6. Sex. 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. JULY Country) 68 n, Day, 1 Yrs. Director 247-64-0314 1941 Usual Residence of Decedent ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1505 RETREAT STREET 21217 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 AUTOMOBILE DETAILER AUTOMOBILES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ALBERT JACKSON LOUISE PROCTOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAMIE DARDEN/SISTER 1317 WILLIAMS ST. GLEN BURNIE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) ON-SITE CREMATION 6-4-2010 BALTIMORE, MARYLAND 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. re of Funeral Service Licenses -31 LAURENS ST TIMORE, MD BAT 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final multi -Physician/ -05900 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner eptic 5 Sequentially list conditions, if any leading to impossible cause. Enter Underlying Examiner One-to for A s a ponsecuence of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2—hould be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (specify) _____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy perform Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: မ 1 Yes 2 opatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Naturai 2 Accident Cuicide work? 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 66108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.D. Bultimore 2 000 W. 31. Date filed (Month. 4 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 25. 2010 JOHN WAYNE JONES JR. 12:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER HARFORD 8. Date of Birth (Month, Day, Year, Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 XM 2 🗆 F Hours Director Ľ950 Maryland 212-60-3363 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Marvland | Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3001 Reckord Road 21047 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Owner/Operator Trucking Company Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Gladys Elizabeth Zealor John Wayne Jones Sr. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3001 Reckord Road, Fallston, MD 21047 Barbara A. Jones / Wife Baltimore, 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State 1 🛭 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5-29-10 Memorial Bel Air. Marvland permit. 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ h87ABOLIC tedosis disease or condition resulting in death) EVELE Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, Awiz To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Yes 1 ☐ Yes 2 ☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by JUMONAM OSSTAUCTIUE 1 Yes No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed' 0386120 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner2 Hospita Other: 1 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1. Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 5/25/10 066342 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kapilky mar Patci, mo CHESAPEAKE 31. Date filed (Month, Da State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 Pauline June Gentry Jones 8:35 A.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Air If Under 24 Hrs. Hours Min. Jacob's Well Assisted Living Bel r 1 Year Harford Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Linder 8. Date of Birth (Month, Day, Months Davs 1 □ M 2 🛣 F 84 North Carolina 5, 1925 214-24-3583 Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 232 Crocker Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify. 3 □ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Cashier Grocery Store 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Della William (unk) Gentry Tilley (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Hensley / Daughter 1301 West 8th St., Mesa, AZ 85201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn 6-4-10 Bel Air, Maryland 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility. McComas Funeral Home, P.A. McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingd 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCIEROTTE CAR DIOVASCULAR DISEASE OVER SHEARS disease or condition resulting in death) Due to (or as a consequence of) PERIPHERAL ARTERY DISEASE AMPOTATION BELOW KIND Due to (or as a consequence of): JUEEKS GERGRENOUS 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4 ☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? BI FEHORAL STENTING 8 WEEKS t ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an UROSEPSIS performed? Yes 2 No 26. Place of Death (Check only one)

Physician /Medical **Examiner**

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attending physician for use as the buria

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page 2

director

certificate

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ortant: If item 27 Is marke injury or other traumatic

permit. Pages Department of Important: If its any injury or o

Pages 1 and 2 should be f nent of Health and Mental

hours after

within 72

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 28c. Injury at Work? 28d. Describe how injury occurred

1716 HARPORD Rd SU 105 FALLSTON

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 ☐ Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 30. Name and A least person who completed cause of death (Item 23a) (Type, Print)

29c. License number DDO16389

JUNE1, 2010

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Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0.5 Day 28 01: 30 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE NIA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Days Months Hours Month, Day, Country) Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 2450 212 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian the Medical Examiner Armed Forces?
1 See 2 No þ Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify 3 🗆 Widowed 4 🗆 Divorced If Yes, Give Specify: Blac Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MOVIQ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - Çity or Town, State permit. Page 1 Department of I Important: If it 1 Burial 2 Cremation 3 Removal from State th may injury 4 Donation 5 Other (Spegify) 21. Signature of Funeral Service I censee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of) **Examiner** ILATED CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence oi). attending physician and for use as the burial-transit HYPERTENSION Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ned by the atter detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MYPERLIPIDEMIA DIABETES Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 🗌 Yes Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) Kaunakar M.D. RES -000 05/28/ 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCHRAVEN BLVD, AKASAPU BALTIMORE, MD-21239 31. Date filed (Month, Day, Year) State Registrar

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010° 27 May 6:26 P M Barbara Μ. Kurtz Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Hours January 24, 1925 217-44-5675 **Director** 85 Yrs. Canada Usual Residence of Decedent 28a-f shov Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho any Injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? 8005 Custer Road 20814 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed tment of Health and Mental Hi tant: If item 27 is marked otl 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edith Dorothy Plant Frederick Fitzroy Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9205 Lundigan Court, Bethesda, Maryland 20817 <u>James F. Kurtz / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Arlington National 4 ☐ Donation 5 ☐ Other (Specify) June 29, 2010 Arlington, Virginia Cemetery Signature of Funeral Service Licensee The first service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Years Ruptured Abdominal Aortic Aneurysm Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in listed according to the condition of the c Due to (or as a consequence of) Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Hypertension, Asthma, Arthritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. to Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🔀 No Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mwid un May 27, 2010 D55779 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 Hasitha Wickramasinghe,

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31. Date filed (Month, Day, Year)

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egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ RICI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Compassionate Assisted Living Millersville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. Aug 18, Pennsylvania Director T932 77 160-26-5739 Usual Residence of Decedent Iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director 1 ☐ Yes 2🏝 No Millersville Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21108 USA 271 W. Pasadena Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify "natural", 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation unk 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Keeley John Rodgers permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. McClure/daughter 801 Cedarcroft Road; Millersville, Maryland 21108 or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ₺ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice ²² Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street timore. Maryland East Timore, Mary Tano

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ 0) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir sician and burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 🗌 Yes Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital 1 Yes 2 100 ပ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending injury Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one ENSE HEAHWAY ANNAPOYSMD 21401 who completed cause of death (Item 23a) (Type, Print) ame and address of p ICHAE 31. Date filed (Month, Day, Year) 32. Regis State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Scott Leake 5:26 P. M 30 2010 May Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Timonium Baltimore County Stella Maris Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Secunty Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min 1 XM 2 □ F 216-98-9868 44 1966 Athens, GA Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10c. City, Town or Location of Health and Mental Hygiene. item 23a or 28a-f sho item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medic al Examiner must be notified at Director Harford County Abingdon Maryland 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 Funeral 3937 Bush Court United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 【XNo If Yes, Give þ 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Co. Schools Teacher 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 Is marked of any Injury or other traumatic eve Brenda Diane Malone ည William F. Leake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3937 Bush Court, Abingdon, Maryland 21009 Lisa Leake (Spouse) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 1,2010 Forest Hill, Maryland Evans Funeral Chapel Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—BelAir 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the Usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ **GLIOBLASTOMA** disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying for use as the burial-transit Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** Be Hospital: Other: 2 X No ျ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 🗶 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY VALLEY RD. JENNIFER HAUF, TIMONIUM, MD 21093 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month 16:28 LANDGRAFF 2010 JOHN 446 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death of Maryland Medical Confer Baltimore 8. Date of Birth (Month, Day, Year) Aug 12, 1 9. Birthplace (State or Foreign Year | If Under 24 Hrs. Age (In yrs. last birthday) 1**™** M 2□ F Days Mary Land 55 217-58-8599 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2410 Saratoga Avenue 21227 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ₩ No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 10 Heavy Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lorelei Hacker Theodore Landgraff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3343 N. Chatham Road, Ellicott City, Maryland 21042 <u>Lois Landgraff, Wife</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/3/2010 Baltimore, 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonay hemorrhage
Due to (or as a confequence of): morths Pulmonay wetastation Sequentially list conditions, if any, reading to infineduate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cancer Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Ye ar in the past 12 months? Month Day

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Examiner Exami attending physician and for use as the burial-tran Physician/Medical signed by the a d be detached for ģ Be Completed Certification: To I or Attending P after death. To the Hospita.

within 24 hours after death.

To the Funeral Director: After The Funeral Director After The Funeral Director After The Funeral Director After The Funeral Director After The Funeral Director After The Fun

Physician

Examiner

Funeral

Director

th and Mental Hygiene.
7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Medical Evans for must be notified at

Department of Health at Important: If item 27 is any Injury or other trau once.

Physician

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death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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1 □Yes 2 □ No 9 □ Unknown		g Unknown	jeath 5 □ Other	(speci	<i>TY)</i>				
Part II. Other significant cond	itions cont	ributing to death but not resi	ulting in the underlying	g caus	e given in F	Part I.		se contribute to the cause of death?	
							24a. Was an autopsy performed? 1 □Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No	
25. Was case referred to medical examiner? 1 ☐ Yes 2 X No				(Check only one)	heck only one)				
		ospital: 1 Inpatient 2 🗆	ER/Outpatient 3	me 5 ☐ Residence 6	G ☐ Other (Specify)				
Z	stigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c.	Injury at Work? 1 □ Yes	ľ	28d. Describe how injury	/ occurred	
3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ld not be rmined	28e. Place of Injury - At he building, etc. (Specif	t home, farm, street, factory, office ecify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
		ician: To the best of my kno er: On the basis of examina and manner stated.						and manner as stated. place, and due to the cause(s)	

State Registrar

Medical

29b. Signature and title of certifier

22 5. Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Sincox
31. Date filed (Month, Day, Year)
JUN 04 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 11:48 Lindt ам Amelia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4300 Cardwell Avenue Apt. 304 Baltimore Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🗆 M 2 🗶 F Month, Day, Davs Hours Min. 213-28-5174 MD Director 79 1931 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No Baltimore Baltimore MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 U.S.A. 4300 Cardwell Avenue Apt. 304 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. o. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced "natural", Completed Specify. Year or Dates White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banking Check Processor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edward Blume Myrtle Fenton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2714 Kildaire Drive, Baltimore, MD 21234 Barbara Jean Lindt, Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Svc._Corporation | 06/07/2010 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road, Baltimore, MD 21214 androcal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it can be a ling to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events PEATE and trar Due to or as a consequence resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death ed by the a Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate Yes 2 No 1 Yes 2 🗌 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Hospital Other: 4 🗌 Nursing Home 5 Residence 6 🗌 Other (Specify 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at '28d. Describe how injury occurred Certificate: 1 Natural work' 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Director; / Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide after City or Town, State within 24 hours aft

To the Funeral Di

completed filled in the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 30. Name and address of person who completed cause of death (Item 22a) (Type, Print) LOCH AAVEN BALTIMOIS MA 3113 -0 5601

Registrar

31. Date filed (Month, Day,

32. Reg

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1644 ELLIE JGAN 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Buzz HAR ASIR M | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Aug • 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 DM 2 F Year) 235-52-1120 Yrs. Director Aug. Usual Residence of Decedent items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medic-I Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 No Harford Aberdeen Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 901 Barnett La. 21001 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 XYes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ➡ No Specify: Completed 3X Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George David Kestner Margaret Anne Carlton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya Shoff / Daughter 812 Prospect Mill Rd., Bel Air, Maryland 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp 6-3-10 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licens McComas Funeral Home, P.A. sontriasce Abingdon, Maryland 21009 Cokesbury Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner - NARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): physician ar Physician/Medical requires that the death certificate be as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No Month Year Day the Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law ate has b autopsy performed certificate 2 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of I Director: After to d in by the funera Certificate: 28c. Injury at 5 ☐ Pending
Investigation
6 ☐ Could not be (Month, Day, Year) 1 Natural work?
1 Yes 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOT ASH, MO ZIVIY NO UPPOR CHOSARGARES DA. SZO VOULUAS 31. Date filed (Month, Day, Year) 32. Regetrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ L'890 MATT William Cameron Latham Jr Medical 4c. County of Peath 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Deatl MARYLAND HEALTH EARE SYSTEM PERRY PUINT 8. Date of Birth (Month, Pay, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 🛣 M 2 🗆 F Days Hours Min. Director 82 215-24-8746 Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No Maryland Harford Aberdeen ъ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4835 Old Philadelphia Road 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Yes, Give "natural", or Completed by 1 Never Married 2 Married KNOWN TO PHYSILIAN : KATA Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Maintenance Man Chemical Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Cameron Latham Sr. Anna Cracroft Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Latham III DE 19977 / Son 1223 Sunnyside Rd., Smyrna, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bakers Cemetery 6-4-10 Aberdeen, Maryland Signature of Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Ent is the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he is the fure. List only one cause on each line. Approximate Interval Between OBSTRUCTIVE PULMONARY -O ISEASE Immediate Cause (Final CHRONIE Onest and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Į Į Month Year 5 Other (specify) the detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe certificate Yes 2 No 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tyes 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 \square Pending work? 1 Tes 2 No `Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c, License number 29d. Date signed (Month, Day, Year) D52739 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND HEALTH CARE SYSTEM SHANDELYA, M.D. 31. Date filed (Month, Day, Year) 37. Registrar's Signat State Registrar

DHMH 17 Rev 7/2009

VOID

CERTIFICATE

2010 - 17457

SEE

CERTIFICATE #

2010 - 18222

Division of Vital Records, To the Hospital

> Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type

4

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year) June 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10c per fb g904 6-4-10 yt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUW F Jesse do 10 09:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 'AN HOSPITAL OFBALTIMORA BALTIMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Country) SC **Director** 01 Usual Residence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 XYes 2 No Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Belleville Avenue LISA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8 Lh Grade College (1-4 or 5+) Bethlehem Steel iteel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benny Mobley Ethel Gregory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATIENT /wife Belleville Adenue Gwynn Oak MD 21207 Lucille Marie Mobley 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge (Imeter) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 6/11/2010 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vallann C. Eveene Funeral Services Vans iberty Road Pandaustown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RESPIRATORY FAILURE Physician/ disease or condition resulting in death) Medical **Examiner** OBSTRUCTIVE PULMONARY SISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transii that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month ed by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BRAIN ANOXIC INJURY 2 No 3 Probably 4 Unknown REWAL FAILURE AULTE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 2 1 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Yedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) of certifi 29d. Date signed (Month, Day, Year) RES 000 JUNE 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BALTIMORE JURGA ABOMAITTIE 31. Date filed (Month, Day State Registrar

DHMH 17 Rev 7/2009

Box 68760. P.O. Division of Vital Records.

> Registrar DHMH 17 Rev 1/2001

0

State

within 24 hours a

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

3001

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IE-CHU,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

HANSUER St. Baltimore,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G904, 6/11/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month とし.D. June 1:11 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltin Hospit-LOUIS 220 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. 0871671948 **Director** 61 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Directo 1 Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 727 DRUID PARK LAKE DRIVE APT 61 21217 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed Specify: 3 Widowed 4 Divorced Year or Dates BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 11 CAFETERIA WORKER MD STATE GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JACK ADAMS EVERLENA RICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. LAKEYVA McDUFFIE 854 ABBOTT CT. BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, MD NATIONAL MEM. PK. 6-10-2010 LAUREL, MARYLAND 22. Name and Address of Facility JAMES A. MORTON & SOSN F.H., INC. 21. Signatu e of Funeral Service Licensee LAURENS AT BALTIMORE, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1+: - organ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner hours Sequentially list conditions, if any leading to immediate Examiner if any leading to immediate cause. Enter Underlying hours Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events cterem, a this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by diabetes, acinetobater 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Dstcomyelitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: Certificate: To 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 66108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daltimire St., Simmons 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 9:10 AM Richard Todd McHenry Tune Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Hart Heritage **Estates** Forest Hill 8. Date of Birth (Month, Day, Ye Aug 12, 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** ^{Year)}1939 1 🛣M 2 🗆 F Months Days Hours Country) 70 **Director** 161-32-4812 Pennsylvania Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2🛣 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 104 Dallas Court USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 XYes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chief of Logistics U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ည permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic o Sarah Kathryn Yost Emil Zephaniah McHenry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Sue McHenry / Wife 104 Dallas Court, Joppa, MD <u>21085</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 6-7-10 Bel Air, Maryland of Funeral Septoe Lensee McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or compensations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Herrt Consistive Physician/ yeurs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exam and -tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f Yes 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page performed' 1 Tes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6X Other (Specify) Assisted 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Living 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: After moleted filled in by the fun 2 Accident Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10.71 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARPHAIL RD BEL AN MD 21014

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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agistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 [] | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifica	ite of L	Death			F	Reg. No).		
Physici	/sician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year							3. Time of Death					
Medical Exam	iner	Gary Dogebii	Maughan						May 31, 2	2010			1921 hrs
		4a. Facility Name (if not institution, give street and number) 2172 20th Street					4b. City, Town, or Location of Death Edgewood				4c. County of Death Harford		
Funeral		Social Security Number 6. Security Number	7. Age (I	n yrs. last birth	day)	If Under 1 Y	_	Inder 24Hrs	_	irth(MN	A/DD/YYYY	9. Birt Foreig	hplace (State or
Director		517–36–7240 1 X	M 2 F	74	Yrs.	Months	ays Ho	ours Min	June	8,	1935_	Cou	^{Intry} Montana
any		10a. State 10b. County	10	c. City, Town o	r Location)							10d. Inside City Limits
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Maryland 28a-f show d at once.	Director	10e. Street and Number				10f. Zip Code	9			10g. Ci	tizen of Wh	at Cour	ntry?
th the Maryland 23a or 28a-f sh notified at once		128 Rigdon	Road			2.	1001		1		US	SA	
h with	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.			Hispanic (pecity Yes or No	0-	14. Race White		can Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once	Fun	1 Never Married 2 X Married	1 v Yes 2	No 74					readily occ.)		i		+-
ırs aftı ural"	ģ	3 Widowed 4 Divorced 15. Decedent's Education (Specify or	If Yes, Give Year 195 or Dates:	4-/4 ted) 16a D		es 2 XXI Usual Occu		_	work done	16b	Specify: Kind of Bus		
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			t of working I				100.	Tana or Bar	7111000711	radotty
036 ithin ane.	μdμ	12	2		C	ivil s	servi	.ce		lt	JS Gov	<i>r</i> ern	ment.
		17. Father's Name (First, Middle, Last)		•			18.Moti	her's Name	(First, Middle,	Maider	n Surname)		
b, MD 21215-0036 and 2 should be filed within 7 teath and Mental Hygiene. Item 27 is marked other than traumatic event, the Medical	o Be	Alton Maughan 19a. Informant's Name/Relationship (T	Dist	1401	B.4'11' A	11			Dunlap				
O & B is is	Ĕ								Rural Route Nu leen, MI		-	ı, State,	Zip Code)
등 등 등 등		Ruth J. Maughan (v	wite)	20b. Place of	Disposition		100		Date			City or	Town, State
imore Pages I ment of F tant: If i		1 Burial 2 XX Cremation 3	Removal from State		y or other			6/3	/2010	T.7.	- L CI		723
Baltimore, permit. Pages 1 as Department of He. Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	see	R.A. I	22. Nan	ne and Addre	ess of Fac	1111		•			er, PA
Balt permit. Departi Impor		Kusteroning	16 (NB/4	Was				Tar	ring-Ca nd 21001	argo I) Fune	ral	Home, P.A.
Physician		23a. Part I. Enter the disease, or compl failure. List only one cause on ea	ications that caused the	death. Do not							ock, or hea	rt	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a.	Drowning co	omplica	ting	Hyper	tens	ive c	ardiova	scu	ılar		Death
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uted nd ransit	Ë	events resulting in death) Last d.	suc to (or as a conseque	orice ory.									
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760, Icate be physici the buri	-ΣΙ	IF FEMALE:	200. II yes, outcome o	f pregnancy						23	d. Date of o	delivery	
ox 68° eath certification attending for use as 1	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time	2. e of death	Fetal		BEcto	ppic pregna	ncy		Month	Da	ay Year
Box 68 death certif the attending of for use as	Physician	1 Yes 2 No 9 Unknown	9 Unknown	ordeath 5	Other	(Specify)							
주 ^학 등 등 등		Part II. Other significant conditions	contributing to death but	t not resulting i	n the und	erlying cause	e given in	Part I.	23e. Did to	obacco	use contrib	oute to the	he cause of death?
S, P.C iires that signed deta	d by								1 Yes	s 2	No 3	Proba	ably 4 🗸 Unknown
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Reco The law cate has									perfo 1 ✓ Yes	rmed? 2 N		eath? ✓ Yes	2 No
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?				26.Pla		th (Check o	only one)				
of Vital ng Physician After this certi nneral director	P	1 ✓ Yes 2 No	ospital: 1 Inpatient		patient 3		Other ₄		-		ence 6 🗸		Scene
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		20a Cartifier	in: To the best of my kno	owledge, death	occurred	at the time,	date and						
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examiner:	On the basis of examina and manner stated.										
F 3 F 5	ž	29b. Signature and title of certifier				29c. Licer	nse numbe	ег		29d.	Date signe	d (Mont	th, Day, Year)
		Lamet outher!	MD			0.0	M.E.			Jun	e 1, 201	٥	
		30. Name and address of person who c			444.5	Danie Ct.	ot D = 1/1	ina e == - 1 '	ID 24224				
		Pamela E. Southall, MD 31. Date filed (Month, Day, Year)	Assistant Medical 32. Regist ar's S			Penn Stre	et, Baltı	imore, M	21201 טו				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 30,2010 **Physician** 53 p M Matthews May Frederick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Frankford Nursing Rehab Cen Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Sep. 27, 1930 220-26-8985 79 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ed other than "natural", or items 23a or 28a-f show event, the Modeal Experience related by notified at Baltimore N/A 1 X Yes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 5423 Radecke Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married Specify: Black Maryland 21215-0036 1 ☐Yes 2€No Specify. 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Rices Bakerv 12th N/A Laborer marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental I ant: If item 27 is marked of Matthews Leroy Winnie Matthews ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 5423 Radecke Ave. Baltimore, MD 21206 Dorothy Matthews/Wife Department of Health Important: If item 27 any Injury or other trong once. Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 6/9/10 Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 21. Signature of Funeral Service Licens 21223 2700 Edmondson Ave. Balto., MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner be executed that initiated events resulting in death) Last burial-trar Box 68760 Due to (or as a consequence of) physician at the burial Physician/Medical attending properties for use as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 Other (specify) P.0. been signed by the should be detached 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed?

1 Yes No page a.□No 1 ☐ Yes certificate ospital or Attending Physician; hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after usa...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03/17

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State Registrar Wallnam

woods Road.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, Petate of Maryland Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30-Alice E. Palle 12:24 PM 2010 Medical 4a_Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death castal Hospice at the Lake Wicomico Salibura If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🗆 M 2 💢 F Hours Min. (Month, Day, Year) Director 29 July1,1920 Maryland Usual Residence of Decedent show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I firem 27 is anarked other than "natural", or items 23a or 28a-f sho important: I firem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 167 Chapel Branch Drive U.S.A. 21801 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 XWidowed 4 Divorced Completed Specify: White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Allan Foster Heisse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Palle/Son Court, Freehold, New Jersey 07728 21Desai 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) ArdentCremationServices Hanover, Maryland 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P.A Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DRMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and s the burial-transit Cause (Lisease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes P No
9 Unknown Pregnant at time of death signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/ No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 autopsy death? 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ဂ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu ☐ Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Q_{\int} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Hulsom

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 22 per fth 9904 6-4-10 yt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death $27^{\,\text{Day}}$ Month 5 20°10 9:33a. M Physician/ Isabelle Perkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death #710 Examiner na Balto Park Lake" 717 Druid Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Months Days Hours 1 □ M 2X□ F Director 06 01 213**-**12-3626 Usual Residence of Decedent 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10a. State Director 1 ¥ Yes 2 ☐ No Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number Funeral 717 Druid Park Lake Drive #71 21217 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black White etc. Armed Forces? þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2x No Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) <u>Private</u> .2th grade Domestic na Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Emma Smith <u>George Jones</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ₩₽ı Druid Park Lake Drive Apt <u> Mildred Jones-Sister</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National: 6/3/2010 Laurel, 4 Donation 5 ☐ Other (Specify) Name and Address of Facility
Wabash Ave March East F/H West F/H Signature of Funeral Service License Balto, MD 211292 Avenue Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) 10 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death g 🗌 Unknown cate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No certificate s after death.

I Director: After this certificate in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 □ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who co

Date filed (Mont)

egistrar's Signati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 19 Toyce Pridgen Year 20 916 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore University of MANYLAMO MEDICAL CENTER 5. Social Security Number 🖦 K If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Months Days Hours 1 M 2 Director Usual Residence of Decedent show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? by Funeral 23a 1994 items permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ò 1 Never Married 2 Married 2 🗹 No ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Completed Year or Dates white other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Dinestk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ *KENC* t of Health and N: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UWK 20c. Location - City or Town, State ò 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Signatur of un ral Service Licens 22. Name and Address 18434 133 23a. Part 1 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HEPATITIS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) -transit and Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical The law requires that the death certificate be 68760 the use as 1 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Pregnant at time of death 5 Other (specify) the page 2 should be detached 9 Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 4 Unknown Completed 1 🗌 Yes 2 No 3 Probably has been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 Tyes 2 🗌 No Accident Investigation in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital completed filled Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one d title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) MO 22054 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V

DHMH 17 Rev 7/2009

State Registrar Scuth Greene Street

Balk more,

21201

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32. Register's Signature

moun

MAN

31. Date filed (Month, Day, Year)

10-04134						
Sylvia	Pritchett					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Sylvia Pritchett	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No.	1/460								
Physician/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	ne of Death								
Medical Examiner	Sylvia E. Pritchett May 30, 2010 19 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	755 1115								
	201 Club House Drive Stevensville Queen Anne's									
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 12-16-1956 Co									
nd show any <u>ce.</u> of	Tod. Glate	Inside City Limits Yes 2 No								
the Maryland Sa or 28a-f show any otified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Sherman Way 21619 U.S.A									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoo injury or other traumante event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Year or Dates: 1 No Widowed 4 Divorced 1 No Specify: 1 Yes 2 No If Yes, Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify:									
5-0036 ed within 72 hours aft tygene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) na College (1-4 or 5†) na 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unemployed	y na								
5-0(lied willied will Hygier Hygier Hygier Hygier Cor										
2121 ould be fi d Mental B s marked itic event,	Robert Briscoe Marie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C	code)								
MD 2 shou th and 1 27 is rumatic	Gregory Ray Pritchett, Sr 9 Sherman Way Chester, MD 21619									
more, ages l and ent of Heal nt: If item	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount 20c. Location - City or Town, crematory or other place) Greenmount 6-4-2010 Balto, MD	State								
taltir	21. Signature of Meral Service Gradee 22. Name and Address of Facility March East F/H	01000								
Physician	23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart App	21202 proximate Interval								
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Tramadol, codeine, and diphenhydramine intoxication Between Onset and Death									
Examiner	or condition resulting in death) Due to (or as a consequence of):									
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
xecuted n and - transit	events resulting in death) Last Due to (or as a consequence of):									
60, e be execut ysician and burial - tra	MUNPENDED AMENDED 23a, 27, 28a-f, per ME g904 6/30/10 TT									
ox 6876 sath certificat attending phy for use as the	23b. Was decedent pregnant in the past 12 months? 25c. If yes, buttorn of pregnant y 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	Year								
cords, law requires has been sig 2 should be npleted		findings available tion of cause of								
tal Reccian: The Lectificate bector, page	25. Was case referred to medical 26.Place of Death (Check only one)	2 No								
Vital I hysician: this certifi I director,	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 V Other: Scen	е								
ion of tending Pheeath. tor: After the funeral the funeral ation: T	27. Manner of Death 1									
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director, ledical Certification: To Be C	3 X suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State) 201 Club F. Stevensville, MD									
D To the Hospital within 24 hours To the Funeral completely filled	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.									
	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Monit									
Ø1	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State Registrar										
DHMH 17 Rev 1/2001	OCME ORIGINAL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death PAUL 2010 UNE 4c. County of Death 4b. City, Town, or Location of Death TOWSON CENTER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 1 💢 M 2 🗆 F Months Days Hours 06/25/1923 MD 86 10b. County 10c. City. Town or Location

Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 02:54 AM NORMAN Medical 4a. Facility Name (if not institution, give street and number) Examiner S'AINT JOSEPH MEDICAL BALTIMORE 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 218-16-1078 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 28a-f shov within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Tyes 2 No CAMDEN CHERRY HILL NJ 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 5 CAMEO COURT 08003 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BUTCHER MEAT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be filk the and Mental H 1 and 2 should be file of Health and Mental Pittem 27 is marked o other traumatic ever ပ္ COPLAN SAMUEL PAUL GUSSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAMEO COURT, CHERRY HILL, RHONA PAUL-COHEN/DAUGHTER item 2 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 6/3/2010 BALTIMORE, MD SHAAREI TFILOH CONG. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility LEVINSON & BROS., AD, PIKESVILLE, MD INC. 21208 8900 REISTERSTOWN ROAD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPSIS Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examiner sician and burial-transit OBSTRUCTION Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) ____ ò in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform 1 🗆 Yes 2 No 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural Accident Suicide 5 Pending 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinat: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nur Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within Z 29b. Signature and title of certifier D 46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON 7601 OSEER DRIVE TABASSI M.D

State Registrar 31. Date filed (Month, Day, Year)

32. Registra 's Signature

10-04119 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 17470 Lupe Paulina Quiroga State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 30, 2010 1150 hrs **Medical Examiner** Lupe Paulina Quiroga 4b. City Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Fiktor Cecil 106 Bow Street 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Months Hours Director 2 XF April24,194 Country) Peru 1 M 68 041-98-2351 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 No Virginia Manassas Manassas hours after death with the Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. ā 9665 Tapok Drive, Apt. 301 20110 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 XMarried 1 Yes 2X No TY Yes 2 No specify:Peruvian 3 Widowed 4 Divorced If Yes, Give Year Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ges 1 and 2 should be filed within 72 of Health and Mental Hygiene. Education 5 +Professor other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dina Huere <u>Maximo Brioso</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 1 1 0 9565Tapok Drive, Apt. 301, Manassas, Virginia item 27 Humberto Quiroga /Husband 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) permit. Pages 1 Department of H 1 XBurial 2 Cremation 3 Removal from State 6-8-10 Fairfield, Con. mportant: LawncroftCemetery Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P Road, Baltimore, Maryland21214 6009Harford 23a. Part I. Enter the diseas 🚀 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed Physician/Medical physician a UNPENDED AMENDED death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Day Year Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown the requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has be performed death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be Division of Vital Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 📗 DOA Other Nursing Home 5 Residence 6 Other this 1 V Yes After 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: May 30, 2010 Passenger in auto roll over and ejected Natural Director: d in by the f Pendina Yes 2 ✔ No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) I-95 SB MM 106.5 , Elkton, MD (Specify) Major Road / Highway To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. May 31, 2010 Whente 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Regi

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 28f per dr., g904,06/04/2010dhb Certificate of Death Reg. No - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Rita C. Ross 2010 2:37 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u>Greater Baltimore Medical</u> Towson 8. Date of Birth (Month, Day, Year) May 7, 1930 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Hours Maryland 80 217-26-9956 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show s itcal Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Elkridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7815 Oxford Drive 21075 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🗶 No Specify. Specify: Black 3

▼ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Teacher Public Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry В. Conway Agnes С. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig A. Ross, son 111 W. Centre Street, Apt. 1006 Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State Metro Crematory, Inc. 05/31/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ndemetria Physician/ disease or condition resulting in death) Medical Due to (or as a o o equence of) 3 months Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ► No Month Day Year Pregnant at time of death is certificate has been signed by the director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ₺ No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, Sity or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 006943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amanda Nickles, Fader, M.D. 12 10569 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g905 7-21-10 vt State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death RIS AM Month Physician/ 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Harwood Mandrin Hospice House 9. Birthplace (State or Foreign 5. Social Security Number 401–66–6458 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 23 7. Age (In yrs. last birthday) **Funeral** Hours Kentucky Months 1 🛛 M 2 🗆 F 62 Yrs. 947 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 XNo Churchton Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20733 5719 Broadwater Parkway USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Me any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Attorney Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Frances Orange John P. Rhody 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5719 Broadwater Parkway Churchton, Maryland 20733 Donna Rhody, Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/04/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final haceal 18ars Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transi The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day signed by the atte in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant a 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Tes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 2 1 🗌 Yes certificate After this certification funeral director, p or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2/No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [] 3 [] (Check only one) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOj 31. Date filed (Month, Day, Year) 32. Re istrar's Signature State JUN 04 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #14, per Ab 9904 6/4/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1200 151AB4 ROMERO Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SILVER SPRING CROSS HOSPITA MONTGOMER If Under 24 Hrs. 8. Date of Birth Hours Min (Month, Day, 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 - M 2 12 F Days Director Usual Residence of Decedent show and Mental Hygiene.
and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f shor is marked other than "natural", or items 23a or 28a-f shor is marked other than Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No KENSINGTOR MONITCOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20895 SA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò 1 Ves 2 □ No Specify: If Yes, Give Year or Dates Specify: **Hispanic** Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NFANT INFVANI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ZELAMA JOEL MARIA FUMAI ROMERO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CROSS MOSPITAL HOLY FOREST GLEN RI 20910 200 MU 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Sign tur, of the Service Licens, Ronald S St Name and Address of Facility Board; 655 W. Baltimore Street Director Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition -h, sician/ PREMIATURI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours a Funeral I Medical 1 Ycertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANN GLEN 1500 forest 31. Date filed (Month, Day, 32. Reg Year, strar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month Physician/ 26 Day 2010 Grace 7:07 P M Marv Rice Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 □ M 2 🛭 F Days Hours May II. 1921 Months 579-10-6155 89 Italy Director Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral items 23a 20854 11305 Gainsborough Road United States hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc should be filed within 72 hours after of and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married δ Maryland 21215-0036 WWII 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
National Institutes of (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franceso Tolotta Rosina Marascio permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John G. Rice / Son 517 Fifth Street, Annapolis, Maryland 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 2, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 2010 . Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 Mystette Bays us M01305 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Physician/ Aspiration Pneumonia A cher ma disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death detached 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hip Fracture or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) May 10, 2010 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 X No OJOOM Fe11 Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
At Home 28f. Location (Street and Number of Bural Route Number, City or Town, State) 11305 Gainsborourgh Rd Potomac, Maryland determined Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) May 28, 2010 D006011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Joon-Shik Park, MD 8600 Old Georgetown Road, Bethesda, Maryland 20814

State Registrar egistrar's Signature

31. Date filed (Month, Day, Year) 32. Registrar's Signature OCME

Assistant Medical Examiner

elle

30. Name and address of person who completed cause of death (Item 23a)

Victor Weedn MD JD

O.C.M.E

111 Penn Street, Baltimore, MD 21201

May 23, 2010

State Registra

			Amend #1 & :	e Type or Pri	nt in Bla	4/10	idelible In	k. Ens	ure All	Copie	s Ar	e Leg	ible.	
			for State Registrar	State Of IVI	ai yiai iu 7		tificate of		and Me	пап пу	Reg. N	2 n +	0	17476
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year	,	μ	5. Social Security Number 6.	105,0/1/0 (e (In yrs. last bi	irth day)	If Under 1 Year	de 16	Chorn.	1		Bal		194C
1	Funeral Director		214-10-3277	Sex 7. Ag 1 M 2 □ F	93	Yrs.	Months Days			5/12/12			9. Birth Cour	place (State or Foreign htry) MD
	and show at	b	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loc	ation							10d. Inside City Limits
	h the Maryland a or 28a-f show be notified at	irect	MD BALTI	MORE	BALT	IMOR	E							1 ☐ Yes 2 🗓 No
	with the 23a or st be r	Funeral Director	10e. Street and Number 7 SUDBROOK LAN	E			10f. Zip Code 212	208			10g. C	itizen of W	/hat Cou	ntry?
	er death with or items 23 miner must		11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	as Decedent of I Yes, specify Cub		gin? (Specif	y Yes or No-		14. Race	- Americ	can Indian,
036		ed by	1 Never Married 2 Married 3 Nidowed 4 Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.	No		☐ Yes 2 X No			,		Specify:		VHITE
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212	within giene. er thar		Elementary/Seconday (0-12)	College (1-4 or 5	+)	TEAC	NOT use retired)			E	DUCAT	TION	
and	ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Last JACOB	FRIEDMAN	-			18. Mothe		irst, Middle,	Maiden		INS	/T
Maryland 21215-0036	1 and 2 should be filed within 72 if Health and Mental Hygiene. item 27 is marked other than "rother traumatic event, the Men		19a. Informant's Name/Relationship		19	b. Mailing	g Address (Street			oute Numbe	er, City o			
	lealt im 2		PHYLLIS ERLICH/	GUARDIAN			FRONT A	AVENUE						
mor	age 1 lent of I nt: If it ry or of		20a. Method of Disposition 1		cemete	ery, crema	ition (Name of atory or other pla HEBREW		Dat 6/2/			ocation - 6	-	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Lice		107.212	22.	Name and Addre	ess of Facility	SOL	LEVI	ISON	& BF	ROS.	INC.
	0.07 = 0.01	\vdash	23a. Part 1. Enter the disease, or cor	nplications that caused	the death. Do		900 REIS					SVILL	.E, N	Approximate
	Physician/		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line				3.			,			Interval Between Onset and Death
أمسه	Medical Examiner		resulting in death)	Due to (or as a	consequence	of):								dry
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68760	ertificat ding ph se as th	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy						\neg			
Box	death o	siciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗆 Fetal deat		Ectopic pregnand Other (specify)	cy				23d. Date Mon		ery Day Year
P.O. I	at the ed by the	/ Phy	9 ☐ Unknown Part II. Other significant conditions		ut not resulting	in the un	derlying cause gi	ven in Part I.		23e. Did to	obacco	use contrib	oute to th	e cause of death?
ds, F	quires the	ed by	1											pably 4 Unknown
Records,	law rec has bee e 2 sho	Completed by								24a. Was a	osy	pr	ior to coi	osy findings available impletion of cause of
al Re	an: The tificate or, pag		25. Was case referred to medical	-			26 P	lace of Death	h (Check on	1 Yes	rmed? 2 N		eath?	2 No
of Vital	hysicia his cer al direct	P	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/O		Lau	or:		5 Resid	lence 6	Other	(Specify)	· · · · · · · · · · · · · · · · · · ·
n of	nding Fath. sth. : After t	Certificate;	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injur (Month, Day,	Yea <i>r</i>) 28b.	Time of injury	28c. Injur work M 1 🗆	yat <br Yes 2 □ I		. Describe h	ow injur	y occurred	i	
Division	or Atter fter des irector n by the	ertifi	3 Suicide 6 Could not 4 Homicide determined	De Diese of Initia	y - At home, fa (Specify)	arm, stree				Location (S			or Rural	Route Number,
۵	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	ical C	29a. Certifier 1 Certifying Phy	vsician: To the best of r	ny knowledge	death oc	cured at the time	, date and n	lace, and di	ue to the car	uso/s) ar	d manner	as state	d.
	the Ho hin 24 I the Fu npleted	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the basis of ex rse Practioner: To the b	amination and/o	or investia	ation, in my opinion ath occurred at the	on, death occ e time, date	curred at the	time date a	nd nlace	and due t	n the cal	lea(s) and manner stated
	Vit CO		29b. Signature and title of certifier	b.			29c. License				29d. Da	te signed (Month, E	Day, Year)
		-	30. Name and address of person who	completed cause of de	ath (Item 23a) ((Type, Pri	nt) 400SU	612			wja	4 2	114	2010
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar	Cou		KB.	2113.	3					
	Registra	_	JUN 0 4	2010	. A	1	arkel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 24,2010 H. Solesky 6:40P. M Lorraine Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist Hospice Care Baltimore Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Aug. 5, 1936 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Days Hours Director 220-34-5452 Maryland 73 Usual Residence of Decedent 28a-f shov 10a. State 10b County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6721 Thruway 21222 Apt.-A U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 XNo Yes, Give 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Joseph Solesky Helen Lepley and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 9306 Raven Ridge Road, Baltimore, Maryland Sabrina Tuck 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State 5030 4 ☐ Donation 5 ☐ Other (Specify) ArdentCrema<u>tionSe</u>r Hanover, Maryland vices 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A muhael margull 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROBABLE Physician/ disease or condition resulting in death) WEEKS Medical Examiner Sequentially list conditions Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

Withe Funeral Director: After this certificate has I completed filled in by the funeral director, page 2.8 completed filled in by the funeral director, page 2.8 performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 X No Other: ည 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred injury 5 Pendina work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert MAY 24, 2010

Registrar
DHMH 17 Rev 7/2009

State

3altimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

BANIEUE DOBERMANIMO 6701 NCHAPLES ST, 8UTE 4105 BALTIMONE. MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death **Physician** Month 8:46 PM Jean Tate Stetler 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Washington Medica BUTTLE Hrunde House If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 💥 □ F Days Hours Min Yrs Director 78 411-42-1807 May 25, 1931 Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No 28a-f Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a 934 Crofton Valley_Drive Funeral 21054 S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ۵ Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, It is Manatic event. Elementary/Secondary (0-12) College (1-4or 5+) Accountant Commercial Business 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ျှ Arthur Tate Minnie Geasley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 5 4 Paul Rudell/Son 934Crofton Valley Drive, Gambrills, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6-4-10 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremationServices Hanover, Maryland 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P. A michael 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ovonav /Medical Due to (or as a consequence f): Examiner hemie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): signed by the attending physician the detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day I ☐Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been: 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy After this certificate perform 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referre to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Certification: To 1 ☐ Yeş 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Man of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. after death. 2 Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hospital Dri 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

P State

Registrar

TEDVAL

31. Date filed (Month, Day, Year)

ICK

32. Registre's Signature

DHMH 17 Rev 1/2001

Hein

Michael Smith Jr. 10-04060 UN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK		Registrar	nt of Health and Mental Hy e of Death	ygiene Reg. No	2010	17479							
Physicia ical Examir		1. Decedent's Name (First, Middle, Last) Prince Michael Duane Smith, Jr. 2. Date of Death Month Day May 27, 2010											
		4a. Facility Name (if not institution, give street and number) Woods to rear of 444 Bel Air Aven∪e	4b. City, Town, or Location of Death Bel Air		c. County of Death Harford								
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 218-27-4516 1 M 2 F 20	y) If Under 1 Year If Under 24Hrs. Months Days Hours Min.		Foreig								
J tow any		Usual Residence of Decedent 10a. State 10b. County Maryland Harford Aberde				10d. Inside City Limits 1 Yes 2 X No							
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	Maryland Harford Aberde 10e. Street and Number 12 South Rogers Street, 2Fl.	10f. Zip Code 21001		itizen of What Cour								
or items 23	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes X No	B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		White, etc.	can Indian, Black,							
and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	ھ	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	1 Yes 2 No specify: edent's Usual Occupation (Give kind of wing most of working life, DO NOT use retire		Specify: Wh								
ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica	\circ	9 Coo		(First, Middle, Maide	estaura n Surname)	nt							
should be fi and Mental 7 is marked natic event,	To Be	Michael Duane Smith 19a. Informant's Name/Relationship (Type, Print) Michael Duane Smith/Father 12	lailing Address (Street and Number or R	Margueri Rural Route Number, (reet. 2F1	City or Town, State	Zip Code)21001							
permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Discrematory.	isposition (Name of cemetery,	Date 20c.	Town, State								
hysician	-	Prichage I Marguels— 23a. Part I. Enter the disease/or complications that caused the death. Do not en failure. List only one cause on each line.	6009Harford Road	d,Baltime	ore,Mar	yland21214 Approximate Interval Between Onset and							
ixaminer		Immediate Cause (Final disease or condition resulting in death) a. Contact gunshot w Due to (or as a consequence of):	ound of head			Death							
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.											
be execurisician and	edical		ME g904 6/8/10 TT										
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregnar Other (Specify)		3d. Date of delivery Month D	ay Year							
ires that the a signed by th	ক্র	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.			he cause of death? ably 4 Unknown							
ial or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed			24a. Was an autopsy performed?	prior to c death?	opsy findings available ompletion of cause of s							
Physician: The or this certificate ral director, page	e B C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpa		g Home 5 Resid	ence 6 🗹 Other	Scene							
Attending Pher death.	27. Mainer of Death The control of the control o												
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the													
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or invessand manner stated. 29b. Signature and title of certifier	29c. License number O.C.M.E.	29d.	Date signed (Mor								
Son	-	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MI		y 28, 2010 								
Sta Registr	17.7	31. Date filed (Month, Day, Year) 32 Registrar's Signature	arkel										
H 17 Rev 1/20		OGME ORIGI		.									

SMITH

CLAYTON

			For State Registrar	State of Marylan	•	rtificate of			giene Reg. No. 🤈	nin	171.80
Phy	ysicia	an	1. Decedent's Name (First, Middle, L	11	. 11			2. Date of Dea		Year	3. Time of Death
/N	/ledic	ai	4a. Facility Name (If not institution, g	Idean 5mi	Th	4h City Town o	r Location of Death	JUNE	2	VOIO	5:25 AM
EX	a:::::::	eı	Envoy Rehab	ilitation Nurs	ins Home	Pik	esville		1	2 11	more
Fun Direc				Sex 7. Age (In yrs. 1 M 2 F	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)		place (State or Foreign
D			Usual Residence of Decedent	/				6-21	1-1911	/	OH
/arylar f show	te pa	ŏ	10a. State 10b. County		y, Town or Loc	cation 1 /				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
h the h	all and a	irect	10e. Street and Number	more Kai	nciali	10f. Zip Code			10g. Citizer	n of What Cour	
ath wit	ust by	ralD	3530 Kesour	ce Drive		21	1/33			USA	
fter de	UNE	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 Noves 2 No	S. 13. V	Vas Decedent of F Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White, e	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	EX	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	□Yes 211No	Specify:		Sp	pecify: Bla	cK
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Maryland Id 2 should be file Ith and Mental Hy	matic	욘	19a. Informant's Name/Relationship	(Time Print)	10b Mailine	Address (Street	and Number or Rura		124	04-4- 7:-	0-4-1
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Itim nit. Pagartmen artmen	n)ury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	ify)	arris	Name and Addre	rst 6-7	2010	Dwin	ss m	ills mi)
Balti permit. Departm Importa	l B a		21. Signature of Funeral Service (ce	nsee Suuse	8	728 L	ss of Facility Vac	J. Ran			neral Serves 21133
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On Of VITAL RECOIDS, P.O. BOX ding Physician: The law requires that the death ce. h. After this certificate has been signed by the attendif fineral intends 2 should be detached for use.	en o	Physician//	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar	death 3□	Ectopic pregnancy	y		23d.	. Date of delive	ery Day Year
that the defended by the		hysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5□	Other (specify)					, 104.
S, F es that igned I		by P	Part II. Other significant conditions	contributing to death but not resu	Iting in the und	derlying cause give	en in Part I.				e cause of death?
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ITAI ian; Ti rtifficate			25. Was case referred to medical	Γ			26. Place of Death	1 □ Yes	2 ØNo	1 □ Yes	2 12 No
OT V Physic		٥	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E			er: 4 Nursing Hor	· · · · ·	'	Other (Specify	1)
SION (tending I leath. tor; After		Certification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year)	28b. Time of Injury	28c. Injury Work	yat :? Yes 2 ∐No	28d. Describe h	ow injury oc	curred	
VISI Atten		E	3 Suicide 6 Could not b	e 290 Place of Injury. At her	me, farm, stree			28f. Location (S	treet and No	umber or Rura	Route Number,
vital or urs after vral Dis				11				City or Town			
UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		Medical	29a. Certifier 1	nysician: To the best of my know miner: On the basis of examinati and manner stated.	vledge, death ion and/or inve	occurred at the tinestigation, in my o	ne, date and place, a pinion, death occurre	and due to the d ed at the time, d	ause(s) and late and pla	d manner as st ice, and due to	tated. the cause(s)
To the vithin To the comp		ĕ -	29b. Signature and title of certifler			29c. License				gned (Month, L	Day, Year)
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-			30. Name and address of person who	16 maiden al	23a) (Type, Pr	rint) lone c	catensvil	e mo	2422	8	
	State	3	31. Date filed (Month, Day, Year)	37 Registrar's Signatu	ire						
Reg	istra	r	JAN A ZA	10 Kenn &	par	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 855 PM Jennie Laura Stinnett mas Medical 4a Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospita N/A timase 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Hours Min 0172471942 Maryland Director 218-44-9069 68 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Shanet 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Co. Randallstown 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5330 Resource Dr. Apt.317 21133 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
12th Grade College (1-4 or 5+) Housekeeper self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jennie William Bogier Laura (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Scott(daughter 5170 Stafford Rd., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. 06/07/10 Baltimore, MD 22.Name and Address of Facility

Joseph H. Brown Jr., Funeral Home
2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licenses ia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ୍ଦ ସ୍ Onset and Death Immediate Cause (Final Physician/ myscardial disease or condition rem haure Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death signed by the at d be detached for Hospital or Attending Physician: The law requires that the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform this certificate ☐ Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 🗆 Yes 2 1 NO Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work 24 hours after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in tilly opinion, death occurred at the first, date and place and due to the first opinion. within 2 only one 29b. Signatu and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAUVIN lean 31. Date filed (Month, Day, Year) State

ORIGINAL

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month Sorilla Theophilus 2:30PM 2010 6 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons's Hospice Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
06 10 29 9. Birthplace (State or Foreign Country) **Trinidad Funeral** Days 1 M 2 - F Months Min. Director 80 Yrs. 217-60-3348 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits NA Baltimore 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3812 Haywood Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 Divorced Black Year or Dates 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Rosewood State Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Assistant <u>7th grade</u> Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Renwick P. Baptiste Maria Sorillo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4019 Grantley Road, Baltimore, Md 21215 Hilda Sorillo-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burlal 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) 6/12/2010 Pikesville, Md Druid Ridge Signature of Funeral Service License 22. Name and Address of Facility
March F/H West 300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that call ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Interval Between Onset and Death ate Cause (Final disease or condition End-Stage Dementra Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed?/ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this of in by the funeral di 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Boute Number. determined City or Town, State) within 24 hours and
To the Funeral Dir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-Skajapakni MiD 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 death (Item 23a) (Type, Print) 2835 Smith AV. S. 235 - Britmore, MO. 21209 N.S. Rajapakse, M.D. 32. Registra s Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (U) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRANCISCA SEVERIN SEPHRA MAL 2010 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S HOSPITAL GEORGE'S CHEVERLY 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗆 M 2 🔀 F 580-11-3765 **Director** 10 - 10ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits GEORGE'S PRINCE 1 X Yes 2 No OXEN HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7302 20745 ABBINGTON DOMINICA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CERTIFIED NURSING ASSIST ANTI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ANTHONY HENRY ANNA BERNARD CETRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SEVERIN <u>VERNA</u> FARMHAMING APT. J. PARKVILLE DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06.07.2010 GÉORGE ADELPHI 21. Signature of Funeral Service Licensee CAPITOL MORTUARY, INC. 0/44/ 22. Name and Address of Facility MARYLAND AVE. 1425 MEBEAN NE. WASHINGTON DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year n signed by the a Id be detached f 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has t performed?
☐ Yes 2 No death? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) MAY 37, 2010 64 27. Manner of Death 28d. Describe how injury occurred STrull by CAR while crossing road Certificate: 28b. Time of 28c. Injury at ☐ Natural MAccident 5 Pending 2107 M 1 ☐ Yes 2 ☑ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Royte Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature a d title of certifier 29d. Date signed (Month, Day, Year) 0/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARNELL 3001 HUSPITAL COOPER DR MJ CHEVERLY 20485 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ Stanton Year 2010 A_{M} Jean 4:50 3 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederi 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) 1 🗆 M 2 🗷 F Months Days Hours Min. Director Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside Çity Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) VWK 18. Mother's Name (First, Middle, Maiden Surname) ပ 21 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Brenda 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Ine Service Licens 22. Name and Address of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End-Stage Immediate Cause (Final (ardiomyopath Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autops, performed? 2 No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 1 🗹 Natural injury 5 Pending ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) MSROJAPUNEM.D 612/10 DOOS7 469 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ØV Baltmort, MD. 21209. 2835 Smith AV-5-235 N.S. Rajapakse, MID. 31. Date filed (Month, Day, Year) 32. Registr State

DHMH 17 Rev 7/2009

Registrar

			For State Registrar	State of M	aryland / Depa <i>Cer</i>	artment of F tificate of L		Mental Hy	giene	10 17485
	Physicia		Decedent's Name (First, Middle, Last, Monica		wmaker			2. Date of De Month May		3. Time of Death 11:45 PM
4	Medic Examin		4a. Facility Name (if not institution, give s	ad			hesda	th	4c. County o	f Death Cgomery
	Funeral Director		5. Social Security Number 220-60-2246 Usual Residence of Decedent	1 A XI = 1	e (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		29, 1936 I	9. Birthplace (State or Foreign Country) ennsylvania
	Aaryland 8a-f show tified at	rector	10a. State 10b. County Maryland Montgo	mery	10c. City, Town or Loc Bethe			-		10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 5414 Harwood Road		 	10f. Zip Code	20814		10g. Citizen of WI	•
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent & Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.	No	Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No- to Rican, etc.)	Bidok	- American Indian, , White, etc. White
Baltimore, Maryland 21215-0036	I within 72 hou ygiene. her than "nat t, the Medica	e Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12) 12		(Give F	ent's Usual Occup kind of work done of D NOT use retired) emaker	ation during most of wo	rking	16b. Kind of Bus	,
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e, Ma	and 2 sho Health an em 27 is I		19a. Informant's Name/Relationship (Typ. John B. Shewmaker 20a. Method of Disposition			Harwood 1		thesda,	Maryland	
Itimor	iit. Page 1 irtment of irtant: If it injury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,		Montgomery C	renatory or other place renatorium	,Inc 20	e 5, 10	Bethesda	a, Maryland
Ba	perm Depa Impo any i		21. Signature of Fundfal Service License Miss Let License 23a. Fan 1 Inter the disease, or complete	A	1101303 175	57 Wisconsi	in Avenue,	Bethesda,	Maryland 2	S1100
	Physician/ Medical Examiner)r	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Advance Due to (or as Severe	e. ed Dementia a consequence of): Diabetes		g, such as cardia	o o respiratory ar	rust,	Approximate Interval Between Onset and Death
ely 8	ite be executed hysician and the burial-transit	dical Examiner	if any, leading to immediate cause. Entire Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Failure	a consequence of): Position Thrive a consequence of):					3
Box 687	Attending Physician: The law requires that the death certificate be executed in death. If death. Schor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transity.		FFEMALE; 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3 L	Ectopic pregnanc	y		23d. Date Mont	of delivery h Day Year
ds, P.O.	w requires that to been signed to should be deta	ゑ	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
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Division of Vital Records,	I or Attending Physician: after death. Director: After this certific i in by the funeral director,	Certificate:	27. Manner of Death 1 M Natural 2	28a. Date of inju (Month, Day	ry 28b. Time of injury	28c. Injury work M 1 \square	/ at	28d. Describe h	now injury occurred	
Ω	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 L Medical Examin	er: On the basis of e	my knowledge, death o xamination and/or investi best of my knowledge, d	gation, in my opinic	n, death occurred	at the time, date a	and place, and due t	o the cause(s) and manner stated
	To th within		29b. Signature and title of certifier		- KX	29c. License			29d. Date signed (Month, Day, Year)
	18		30. Name and address of person who co	r., M.D.	8901 Wisc		enue, Be	thesda,		-
	Stat	-	31. Date filed (Month, Day, Year)	32. Rugistra	ar's Signature	201				

DHMH 17 Rev 7/2009

10-04076 Richard Switalski

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. [1] State of Maryland / Department of Health and Mental Hygiene

		1. For State Critical Certificate of Death Registrar		eg. No.							
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day Year	3. Time of Death 1610 hrs						
Miedicai Examii	let	Richard Walter Switalski 4a. Facility Name (if not institution, give street and number) 14b. City, Town, or Location	May 28, 2	4c. County of Death							
2		Montgomery General Olney		Montgomery							
Funeral Director		295–36–8089 1XM 2F 70 Yrs. Months Days Ho	nure Min	er 3, 1939 Co							
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		=	10d. Inside City Limits						
and show nce.		1 Yes 2 No									
Maryla 28a-f	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 16700 Gooseneck Terrace 20832 United State										
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0 =	Funeral	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No 1 Yes 2 X No specify Cuban, Mexic	can, Puerto Rican, etc.)	White, etc.	can Indian, Black, Thite						
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MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Hetical Transport of the property of the prop										
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MC alth ar sem 27		Kathleen E. Switalski /Wife 16700 Gooseneck		ley, Marylan							
Baltimore, MD : pernit. Pages I and 2 should be partment of Health and Important: If item 27 is injury or other traumating.	١	1 Burial 2 X Cremation 3 Removal from State crematory or other place)	June 3,								
Baltimo permit. Pages Department o Important: I	ŀ	4 Donation 5 Other Specify: Montgomery Crematorium, In 21. Signature of Funeral Service Licensee 22. Name and Address of Fac		Bethesda,							
Depart Depart Injury		21. Signature of Funeral Service Licensee Mol 305 22. Name and Address of Fac Robert A. Pumphre 300 West Montgom	ey Funeral Home ery Avenue, Roc	/Rockville, Ir kville, Maryla	nd 20850-2805						
Physician /M		23a. Partyl. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Drowning complicating atherosclerotic cardiovascular disease Due to (or as a consequence of):										
		Sequentially list conditions, b									
	je.	if any, leading to immediate Due to (or as a consequence of):									
ig 8 . P.	Examiner	(Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):									
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760, cate be physici	Med	#16a, b, perFH, G905, 7/2/2010 IFFEMALE: 23c. If yes, outcome of pregnancy	,WS	23d. Date of delivery	<u> </u>						
Box 687 e death certific the attending p	/sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ector 4 Pregnant at time of death 5 Other (Specify)	opic pregnancy	Month D	ay Year						
BO)	Physi	1 Yes 2 No 9 Unknown 9 Unknown									
Division of Vital Records, P.O. Box 687 rate of Attending Physician: The law requires that the death certific is after death. al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	[€	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		obacco use contribute to t 2 ✓ No 3 Prob							
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an: The riffical tor. pa			ith (Check only one)	2 No 1 Ye	s 2 No						
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Natural 5 Pending Investigation 3 Suicide 5 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Ru or Town, State)											
Div ital or urs afte ral Div	27. Matural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined Subject drowned 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State) (Specify) Swimming Pool 286. Describe now injury occurred Subject drowned 286. Describe now injury										
	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. §ignature and title of certifier 29c. License number 29d. Date signed (Month, D.										
F.2 F.8	₽	29b. Signature and title of certifier 29c. License numb	er	29d. Date signed (Mon	th, Day, Year)						
		Maryente Done Krell O.C.M.E.		May 30, 2010							
10		 Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimo 	ore MD 21201								
Sta	te		70, NID 21201								
Registr	ar	31. Date filed (Month, Day Year) 4 2010 32. Registrar's Signature 9.									

Hudson Abraham Tadors

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State of Maryland / Department of Health and Mental Hygiene	 U I	U	2
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		1- For State Registrar			Certific	ate of	Death				Reg. No	D .		
Physici		1. Decedent's Name (First, Mid	die,Last)							2. Date of De Month	ath Day	Year		3. Time of Death
Medical Exami	ner		aheim Ta		5					June 1, 2	2010			1350 hrs
400		4a. Facility Name (if not institut 816 Providence Road	- · -	iumber)		4	b. City, Town, o	or Location	n of Death			lc. County of Baltimore		
Funeral		5. Social Security NumberUNK	6. Sex	7. Age (Ir	n yrs. last birl	thday)	If Under 1 Ye		der 24Hrs.	8. Date of E	Birth(MN	//DPAYXYY)	9. Birt	hplace (State or
Director			1 M 2 F		44 -45	Yrs.	Months Da	ys Hou	ırs Min.	June	21	,1961	Co	n Amman
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland men to & Heath and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 816 Provide:	nce Road				10f. Zip Code 212	86			10g. Ci	tizen of Wha USA	at Cour	itry?
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and 2 lealth tem 2 traun	-	20a. Method of Disposition			20b. Place o	f Dispositi	on (Name of ce	emetery,	T	Date	20c.	Location - C	City or	Fown, State
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		or condition resulting in death)	Due to (or as	a conseque	ence of):									
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Division of Vital Records, P.O. Box 68 tall or Attending Physician: The law requires that the death certifrs after death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	d by									1 Ye	s 2	No 3	Proba	ably 4 🗸 Unknown
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8 1		30. Name and address of person Pamela E. Southall, N			` '	111	Penn Stree	t, Baltin	nore, MD	21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 0302AM /Medical 2010 4a. Facility Name (If not institution. give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 0 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗓 F Months Days Hours Yrs. Director 88 213-20-0533 09 09 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 23a or Funeral 3021 Seaman Ave 21225 U.S.A. or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, its Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>9th grade</u> Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Thomas E. Taylor Willie Beatrice Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3834 Flmley Ave, Baltimore, Md 21213
e of Disposition (Name of Date 20c. Location - City or Town, State Carolyn Lowry-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet 6/4/2010 Crownsville, Md 21. S snature of Funeral Service Licen se 22. Name and Address of Facility larch F/H Wes F/H We Wabash March West 4300 Ave, Baltimore, Md 23a. Part 1. Enter the visease, or complications that caused the shock, or hear failure. List only one cause on each line. Immediate Cause (Fig. 1) dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and Death Physician TRUMANIA disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner 5 AN may Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a managuence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran denentia 40w-Due to (or as a consequence of): Division of Vital Records, P.O. Box 6876 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 □ Yes 2 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☐Ko 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗆 No by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 75161an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Hanson 300) Michae VEIMA O 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ ROBERT GEORGE TERVEER Day Year JUNE 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 1X□ M 2 □ F Months Days Hours Min 220-42-7914 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD TOWSON BALTIMORE 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8324 THORNTON ROAD 21204 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 X Married þ ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FLOOR MECHANIC SELF EMPLOYED 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 FRANK B. TERVEER MAXINE E. BERNARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLY A. TERVEER/WIFE 8324 THORNTON ROAD TOWSON. MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY, 6/7/2010 INC. CATONSVILLE. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) montus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due o (or as a consequence of) Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery

Unysician/ **Medical** Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

7 if them 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at

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Department of H
Important: If ite
any injury or ott

Baltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-transii ian/Medical Physic signed by 1 ۾ page 2 should Certificate:

Jas

certificate

After this

within 24 hours a To the Funeral

Physicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day Year				
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æ	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	,				
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29c. License number

29d. Date signed (Month, Day, Year)

hands ST POW SON MU)

State

4

Registrar

29b. Signature an

31. Date filed (Month, Day, 32. Registrar's Signature

BUNNER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		101	State of Maryla	nd / Depa	artment of H	lealth and	d Mental Hy	giene				
		State Registrar		Cer	tificate of E	Death		Reg. No.				
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Exam	niner		•		4b. City, Town, or		eath	4c. Cour	nty of Death			
1		1223 Marston Driv			Bel Ai				ford			
Funer: Directo		5. Social Security Number 6. Sex 1 1	7. Age (In yrs. 66		If Under 1 Year Months Days			th y, Year) 1944	9. Birthp Count Maryl	lace (State or Foreign ry)		
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and shov	٥		10c. C	ity, Town or Lo	cation				1	Dd. Inside City Limits		
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lan,		19a. Informant's Name/Relationship (Type,		19b. Mailin	g Address (Street a	and Number or i	Rural Route Numbe	r, City or Town	, State, Zip C	ode)		
		Melissa McCready /	Daughter	1400	Greenspri	ing Val	ley Rd. S	tevens	on, MD	21153		
Ore e 1 au t of H if itel		20a. Method of Disposition 1 ☐ Burial 2 ★★ Cremation 3 ☐ Re			sition (Name of natory of other place Eral CHa r	e) - Ju	ne 4,	20c. Location	n - City or To	wn, State		
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		4 ☐ Donation 5 ☐ Other (Specify)	EV	Rol Ai	r			Forest	Hill,	Maryland		
Ball	ouce	21. Signatur Funeral Service Licensee	_/	22	Name and Address	s of Facility						
		Jour Xeeau	go						yland	ce-BelAir 21050		
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DIVISION Of VITAI HECC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	(Check 2 ☐ Medical Examiner	n: To the best of my know On the basis of examination	n and/or investi	gation, in my opinior	 death occurre 	ed at the time date as	nd place and d	lue to the caus	se(s) and manner stated		
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FRFS		Dr. 1 19th	warm dit					29d. Date sign				
		30. Name and address of person who com	pleted cause of death (Item	n 23a) (Type Pr	int)	ve je	1	00-	01-	10		
		Renalid E. Thomas	~ UD0 3445	E BON	Hill Coup	Centr	r tr. Als	inada	ded. 2	-1009		
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Regist	rar	JUN U 7 20	New Men	1	-1-1-1							

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Edwin C.	٧

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State of Maryland / Department of Health and Mental Hygiene

dwin C. Warfiel	·	r. State of N 1- For State Registrar	Maryland / De	epartment Certificate			Ment	al Hy		eg. No.	201	0 17491	
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle, Last) Edwin C. Warfield,	Jr.						Date of Dea Month June 1, 20	th Day	Year	3. Time of Death 1907 hrs	
Contract of the second		4a. Facility Name (if not institution, give street 1009 West 38th Street	et and number)			y, Town, or Li Itimore	ocation of				ounty of Dea		
Funeral Director		5. Social Security Number 6. Sex 220–42–6951 1 XM		rs. last birthday)	Mo	nths Days	If Under Hours		8. Date of Bir Feb 3		For	Birthplace (State or eign Country) Maryland	
d how any ee.		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Loc		more						10d. Inside City Limits 1 X Yes 2 No	
ith the Maryland 23a or 28a-f show notified at ouce.	irect	Maryland N/A 10e. Street and Number		D		Zip Code			1	-	Citizen of What Country?		
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shummatic event, the Medical Examiner must be notified at once	— L		C Was Decedent Ever i Armed Forces? Yes 2 X N	Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto							USA 14. Race - American Indian, Bla White, etc.		
2 hours after "natural",	ā	3 Widowed 4 Divorced If Yes on Da 15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	tes:		ent's Us	2 No ual Occupatio working life. [n (Give ki				ecify: W	hite s/Industry	
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	\sim	17. Father's Name (First, Middle, Last)	4	Mecha	nica	l Desi			First, Middle, N		vales rname)		
D 2121 should be fi and Mental is marked	To Be	Edwin Warfield 19a. Informant's Name/Relationship (Type, F	rint)	19b. Mail	ing Addr	ess (Street a	and Numb	er or Ru	Yono ral Route Num	nber, City	or Town, Sta	ate, Zip Code) 21210	
	ŀ	Mary Jeske, Wife 20a. Method of Disposition 1 Burial 2 Cremation 3 Re	moval from State	0b. Place of Disp crematory or	osition (i other pla	lame of ceme ce)	etery,		Date	20c. Loc	cation - City	altimore, MD or Town, State	
Baltimore, permit. Pages I an Department of Hea Important: If itee	_1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Thomas Gre	12	rema 99 F	tion S rederi	Facility OCIE ck R	ty 0 oad	3/10 f Mary Baltim	land,	Inc. Maryl	e, Maryland and 21228	
Physician Medical vaminer	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
	iner	Sequentially list conditions, b	o (or as a consequence										
executed an and al - transit	Course. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.												
esici	Medical	IF FEMALE: 23c	ENDED If yes, outcome of p	pregnancy		_		_		23d. D	ate of delive	ery	
Box 6876 e death certificate the attending phy ed for use as the t	nysiciai	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9	Live birth Pregnant at time o Unknown	f death 5	etal dea	pecify)	Ectopic p		:y	Mo	onth	Day Year	
S, P.O. uires that the signed by Id be detach	≦	Part II. Other significant conditions control Diabetes Mellitus; Chronic Alc		ot resulting in the	underly	ing cause give	en in Part	I.	1 Yes	2 N	lo 3 Pr	to the cause of death?	
tal Records, cian: The law require certificate has been si ector, page 2 should t	Completed								24a. Was a autop perfor	sy med?			
ician: s certif	8	25. Was case referred to medical examiner? Hospita	l: 1 Inpatient 2	ER/Outpatie	-4 0	26.Place of	thor:		,,		- []	_	
Afte	ation: To	1	Ba. Date of Injury (Month, Day, Year)	28b. Time o		28c. Injury		28	Home 5			er: Scene	
Division Hospital or Attend 24 hours after death Funeral Director:	Certification	3 Suicide 6 Could not be determined (8e. Place of Injury - A S <i>pecify)</i>	At home, farm, str	eet, fact	ory, office buil	lding, etc.	28	8f. Location (S or Town, S		Number or F	Rural Route Number, City	
Fo the within Fo the comple	edical		the best of my know e basis of examination nanner stated.	rledge, death occ on and/or investig	ation, in	my opinion, d	death occu	e, and du irred at th	ue to the caus he time, date a	e(s) and m and place,	nanner as sta and due to	ated. the cause(s)	
		29b. Signature and title of certifier		20		O.C.M.					e signed <i>(M</i> 2, 2010	fonth, Day, Year)	
4		30. Name and address of person who comple Russell Alexander MD. Assis 31. Date filed (Month, Day, Year)	ted cause of death (I stant Medical Ex 32. Fegistrar's Sigr	aminer 11	1 Pen	n Street, B	Baltimore	e, MD	21201				
Sta Registr	_	31. Date filed (Month, Day, Year)	August at a sign	1 60	nde.	0							
DHMH 17 Rev 1/200)1		/	ORIGIN	AL						OCME	-	

for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Williams Elizabeth Frances Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 00 Itemorp Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days 1 □ M 2 🔀 F Months Hours 218-14-9492 95 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at Director MILLIAM N/A Baltimore 10f. Zip Code 10e. Street and Numbe 23a or Funeral vith 1 2501 Violet Ave. 21215 Apt.609N items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 2 1 Never Married 2 Married ō ☐ Yes 2 XNo 1 ☐ Yes 2 X No Specify: If Yes, Give and Mental Hygiene. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Housekeeper 17. Father's Name (First, Middle, Last) Baltimore, Maryland Coulter (unk) 19a. Informant's Name/Relationship (Type, Print) f Health 2501 James Williams(son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility JOSeph H. BROWN Jr. 2140 N. Fulton Ave. 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ HEART FAILURE disease or condition resulting in death) ONGESTIVE Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by has e 2 page is certificate h Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **N**0 ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mann eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No thin 24 hours after death.
the Funeral Director: Aimpleted filled in by the fu 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within To the 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2. Date of Death 3. Time of Death JUN 2010 4c. County of Death N/A 9. Birthplace (State or Foreign Maryland 16770471914 10d. Inside City Limits 1 Sy Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, White, etc. Black 16b, Kind of Business Industry self-employed 18, Mother's Name (First, Middle, Maiden Surname) Margaret(unk) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Violet Ave. Apt. 609N, Balto., MD 21215 20c. Location - City or Town, State 06/08/10 BAltimore, MD 21217 Approximate Interval Betwe set and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) JUN 02 Belvedere Ave Baltimore MD 21215

State Registrar 18beth

31. Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

2401

32. Régistrar's Signature

10-04004 Joseph Webb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Time of Death Month Day May 25, 2010 Medical Examiner 1655 hrs Webb Joseph 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1724 North Bradford Avenue Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min Director 050-38-8688 5-24-1953 1 XM N.Y 2 F 57 Yrs Usual Residence of Decedent 10a. State n, 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1X Yes 2 No na Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? notified at 1724 N. Bradford Street 21213 U S 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 2 X No Black If Yes, Give Year Divorced 1 Yes 2 No specify: Specify <u>≨</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unemployed is marked other than ' MD 21215-0036 unemployed lyr 12th grade 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) unk Goldie Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21217 Charles Hodge-Friend 2210 Linden Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Chapel Hill Mem 4 Donation 5 Other Specify Chapel Hill, 6-7-2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H North Avenue MD 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and Medical a Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) ite. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death and Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 DOA After this 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 26, 2010 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day State LEUR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Linda Washingt	on	1- For State Registrar				artment o ertificate o	f Health and f Death	d Mental F		eg. No.		1749		
Physici Medical Exam			ne (First, Middle,Las Vashingtor			-			2. Date of Deat Month	Day	Year	3. Time of Death 1043 hrs		
and and and and and and and and and and		4a. Facility Name (if not institution, give		ber)		4b. City, Town, or I	Location of Deat	May 23, 20		nty of Death			
Funeral		1644 Ruxto	n Avenue	x 7	Age (In vrs	last birthday)	Baltimore If Under 1 Year	If Under 24Hr	s 8 Date of Birt	b/MM/DD/X	vvvl a Rid	thplace (State or		
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any		Usual Residence o 10a. State	f Decedent 10b. County		10c. City	, Town or Loca	tion			100				
and show	5	MD			Ва	.1timore						1 X Yes 2 No		
he Maryl. 1 or 28a-f	Director	10e. Street and Nu	mber ixton Aver	nue			10f. Zip Code 21216		10	g. Citizen of USA	What Cour	ntry?		
2 21215-0036 hould be filed within 72 hours after death with the Maryland hould be filed within 72 hours after death with the Maryland is marked other than "natural", or items 23a or 28a-f show any stir event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Marrie		12. Was Deced	es?unk		as Decedent of Hisp es, specify Cuban,				14. Race - American Indian, Black, White, etc.			
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5-0(iled wi Hygies d other		17. Father's Name	(First, Middle, Last)			I	1	8. Mother's Name	e (First, Middle, M	aiden Surna	me) unk			
2121 Jld be f Mental marked: event,	o Be	19a. Informant's Na	me/Relationship (Tv	rpe. Print)		19b Mailine	Address (Street	and Number or	Pural Pouta Num	har City or T	Town State	Zin Code)		
MD 21215-0036 and 2 should be filed within 7 alth and Mental Hygiene. m 27 is marked other than aumatic event, the Medica	-	0.C.M.E		,,,,,,,,		1	Penn St							
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	į į	20a. Method of Disp	Cremation 3		State	Place of Dispos crematory or otl	ition (Name of cem her place)	etery,	Date	20c. Location	on - City or 1	Fown, State		
Saltir rmit. I epartm aporta jury or	Donation 5 X Other/Specify in state / 22 Name and Address of Facility Ronald S. Wadle, Firector State Anatomy Board; 655 W. Baltimore											e Street		
Physician												Approximate Interval		
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive cardiovascular disease												
Examiner	or condition resulting in death) Due to (or as a consequence of):													
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x 6876 h certificate tending phy use as the t	W/W	IF FEMALE: 23b. Was decedent p		23c. If yes, out	contro or prog		al death 3	Ectopic pregna	incv	23d. Date Month	of delivery	ay Year		
Box 68760, c death certificate be the attending physic ed for use as the buried for use	Physician/N	past 12 months		4 Pregnant	at time of de		ner (Specify)			l mana		ay rear		
D. B. It the de by the	Phy	Part II. Other signif	bio.compl	g Unknown		esulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use co	ntribute to th	ne cause of death?		
, P.O. res that th signed by be detach	d b	Sarcoi					, , , , , , , , , , , , , , , , , , , ,				_	ably 4 Unknown		
ords w requires been should	olete								24a, Was ar			opsy findings available impletion of cause of		
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed								perform 1 Yes 2	red?	death?			
Vital Rey ysician: The his certificate director, page	B B	25. Was case referre examiner?		spital: 1 Inna				of Death (Check of						
n of V ding Phys I. After thi funeral di	밁	1 ✓ Yes 2 27. Manner of Death	2 No	28a. Date of I	njury	ER/Outpatient 28b. Time of In	v □ 2011	- Indiani	g Home 5 R	esidence 6		Scene		
ion tendin leath. tor: A	aţio	1 X Natural 2 Accident	5 Pending Investigation	(Month, Da	y,Year)		1 Ye	s 2 No						
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and optietely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e Place of	Injury - At ho	ome, farm, stree	t, factory, office bui	iding, etc.	28f. Location (Str or Town, Sta		nber or Rura	al Route Number, City		
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier 1 (Check only one) 2	Certifying Physicial	n: To the best of On the basis of e	xamination ar	ge, death occurr nd/or investigati	ed at the time, date on, in my opinion, d	and place, and death occurred a	due to the cause(t the time, date ar	s) and mann nd place, and	er as stated due to the	f. cause(s)		
H 3 H 3	ğ	29b. Signature and t	itle of certifier	\cap			29c. License		ľ	29d. Date sig		h, Day, Year)		
			(N X)	ello)			O.C.M.	.E.		May 24, 2	2010			
		30. Name and addre Laron Locke		mpleted cause on nt Medical E	•		Street, Baltimo	ore, MD 2120	D1					
	~~	31. Date filed (Month	n, Day, Year)	32. Regis	trar's Signatu							-		
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alice Madeline Zentgraft June 7:10 P_M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
April 15, 1925 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Davs Hours Maryland 219-16-4179 85 Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Baltimore 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 9505 Teaberry Lane 21234 U.S.A. items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc. ō 1 Never Married 2 X Married ۾ 21215-0036 . Hygiene. other than "natural", 1 ☐ Yes 2 🛛 No Specify: Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
As sembly Worker any injury or other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Black & Decker Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last)
Clarence Bernard Houck Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) ٥ Edna Pearl Shanklin 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 9505 Teaberry Lane, Baltimore, Maryland 21234 Wesley Eugene Zentgraft 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 7, More Tard Major Itar P^{lace)} Park Parkville, MD 2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation 8800 Harford Road, Parkville, MD 21. Signature of Funeral Service Licenses art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Physician/ rooten sease or condition sulting in death) Medical Due to (or as a consequence of) Examiner recus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transit requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Pyes 2 No Month Day Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law page 2 s autopsy performed? 2 🗆 No 1 Yes 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be 1 Yes Other: 2 DaNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No Natural Natural 5 Pending 124 hours after death. e Funeral Director: At Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Alma Doris Zimmerman 2010 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Regional HOSPITA _dure Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. June 9, 1920 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Balt., Maryland 1 □ M 2 🗗 F 89 213-16-4761 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Timonium 1 ☐ Yes 2X No Baltimore Maryland with the 10f. Zip Code United States 10e. Street and Number 21093 115 Deep Dale Drive of America Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No white altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnus Margaret Vincente John Waicker ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau 9306 Jasmine Court Laurel, Maryland 20723 Robert M. Murphy/ nephew 20b. Place of Disposition (Name of cemetery, crematory or other plan Gardens of Faith Cemetery 20c. Location - City or Town, State June 7 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale, Maryland 4 □ Donation 5 Other (Specify) Entombment 2010 21. Signature of Funeral Service Lice Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Small Immediate Cause (Final Bowel **Physician** disease or condition resulting in death) * /Medical Due to (or as a consequence of): Cancer of Unknown Primary Examiner Abdominal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Severe 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate Be director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To After this nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

ျှ

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abdul Munim, MD Laurel Regional Munim Registrar's Signatu 31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

29c. License number

7300

Laure

29d. Date signed (Month, Day, Year)

Dusen Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 30, Physician/ John Zusy 2010 4:58 p. M Frederick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10009 Frederick Avenue Montgomery Kensington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Jan. 9, 9. Birthplace (State or Foreign Country) Wisconsin Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 🕅 M 2 🗆 F Hours 1914 96 **Director** 394-10-4480 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f shov idical Examiner must be notified at death with the Maryland Director Kensington MD Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10009 Frederick Avenue 20895 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 2 No II by 1 Never Married 2 K Married X Yes Baltimore, Maryland 21215-0036 within 72 hours after White 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Associated Press <u>Journalist</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Anna Deutche Louis Zusy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. 10009 Frederick Ave. Silver Spring, MD 20910 (wife) Mary Jane Zusy 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of June Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Beltsville, MD. 2010 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facilin Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Coronary Vascular Disease years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09577 June 2, 2010 QX) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10400 Connecticut Ave. Suite 606, Kensington, MD 20895 Richard Pollen, M.D.

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

32. Pigistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ammas Yesuvadian Abraham May Month 20**1**0 Medical 2:40P. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 215-98-0931 Months Days Hours Min. Director 92 Jume 1,28, Year 917 India Usual Residence of Decedent with the Maryland items 23a or 28a-f sho ler must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Maryland | Montgomery Takoma Park 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7051 Carroll Avenue, #312 20912 India death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner Was Deceuent Armed Forces?

1 ☐ Yes 2 🛣 No Race - American Indian Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 3 X Widowed 4 □ Divorced If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Completed Asian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Porter Hospitality other traumatic event, Be 17. Father's Name (First, Middle, Last) and Mental H 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve ၉ Yesuvadian Gnanamuthu Selvam Rasaiya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Dharmadas Abraham -son 1310 Canyon Road Silver Spring, Maryland 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) George Washington Cem. 6/3/2010 4 Donation 5 Other (Specify) |Adelphi, Maryland 21. Signature of Funeral Service Licens 23 Name and Address of Facility ardt Funeral Home, 4400 Powder MILI Road Beltsville, L 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final ∢∩ysician/ Onset and Death disease or condition resulting in death) <u>Aspiration Pneumonia</u> Medical Examiner Conjestive Heart Failure Sequentially list conditions, if any, and it is in include cause. Enter Underlying Cause (Disease or iinjury Examine or Attending Physician: The law requires that the death certificate be executed Acute Chronic Renal Failure and -trans that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Atherosclerotic Heart Disease Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Yes Day Year 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? director, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2X No certificate 1 ☐ Yes 2 🕅 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) မ 1 🗌 Yes 2 X No Other: this 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 🗌 Yes Investigation 2 II No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Hospital Medical 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D19971

Registrar DHMH 17 Rev 7/2009

State

Sudhakar, M.D. 7610 Carroll Avenue, #230 Takoma Park, Maryland 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registar's Signature

31. Date filed (Month, Day, Year)

June 1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2010 0029 Lloyd Armstrong Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day,) 1 □ M 2 □ F Days Hours Min. Months 577 46 2064 **Director** Maryland Oct Usual Residence of Decedent 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director Washington DC 1X Yes 2 ☐ No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 1218 C. Street NE 20002 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Black Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the 6th Bric<u>klayer</u> <u>Private</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Isaac Olay Armstrong permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Louise Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) sister 1218 C. Street NE Wash., DC 20002 <u> Corrine Armstrong-Mercer</u> 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place; 1 🗶 Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage Cemetery 5-22-10 Waldorf, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Ligensee 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME · 10nce 2294 Old Washington Rd Waldorf MD 206<u>01</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ SYNDROME disease or condition Medical resulting in death) Examiner RESPIRATORY Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events KIDNEY -HRONIC Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of resulting in death) Last attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PNEVMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎝 Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 🗌 No 1 Yes Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: At the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one death (Item 23a) (Type, Print) ROAD. CLINTON 150 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

	0-03978 Eliana Abreu-Jir	nen		pe or Print i										egib	le.		
			1- For State Certificate of Death											Reg. No.			1 . / 5 U
	Physici		1. Decedent's Name (First, Middle,Last)											eath Da			3. Time of Death 1951 hrs
A	Medical Exami	mer	Eliana Abreu-Jimenez 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death											2010	4c. County of	Death	
2			14241 Kings Crossing		Boyds				2000 FOI DOUBLE				Montgomery				
Ó	Funeral		5. Social Security Number	7. Ag	e (In yrs.	If Under 1 Year If Under 24Hrs.					8. Date of Birth				thplace (State or Foreig		
Š	Director		599-03-9717)3-9717 1□m 2XF				rs. Months Days Hours Mir				Min.	June	16,	6, 1969 Pu		_{untry)} erto Rico
			Usual Residence of Decedent					<u> </u>									
	¥ any		10a. State 10b. County	10c. City, Town or Location											10d. Inside City Limits 1 Yes 2 X No		
	rland -f sho	to	Maryland Montg	Boyds 10f. Zip Code								40- 0	Citizen of Wha	1.0			
	te Maryland or 28a-f show any fied at once.	Director												•			
	5 72 hours after death with the Maryland in "natural", or items 23a or 28a-f sho :a Examiner must be notified at once.		14241 Kings Crossing Boulevard #312 20841 United State												can Indian, Black,		
	eath v item	Funeral	1 Never Married 2 X Married Armed Forces? 1 Never Married 2 X Married White, etc.												,,		
	ifter d il", or	by F												Specify: (Cau	casian	
	ours a		15. Decedent's Education (Spe	5. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kin during most of working life. DO NOT us											16b. Kind of Business/li		ndustry
	36 n 72 h nan ", ical E	plet	Elementary/Secondary (0-12) College (1-4 or 5+)														
	15-0036 filed within 72 hours after of 11 Pygiene. ed other than "natural", of the Medical Examiner n	Completed	17. Father's Name (First, Middle	Last)			Homen	aker	-	18	Mother's	Vame (First Middle		wn Honen Surname)	1e	
	21215-0036 muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Jose Rafael Ab		а					- 1			Jimene				
	213 ould b d Men s marl ic eve	5	19a. Informant's Name/Relations				19b. Maili	ng Addres	s (St	_					City or Town	, State	, Zip Code)
	Baltimore, MD 21215. permit Pages I and 2 should be filee Department of Health and Mental Hy Important: If iten 27 is marked of injury or other traumatic event, the		Elina Abreu-Ji	nenez, Sis	ste:										wn, MI		
	or Heal		20a. Method of Disposition 1 Burial 2 K Cremation	3 Removal fr	om Sta		Place of Dispo crematory or o			cemet			Date 28,	200	c. Location - 0	City or	Town, State
	imo Page ment tant:		4 Donation 5 Other S	pecify:			lantic					<u> 201</u> (G	len Bu	ırni	ie, Marylan
6	Baltimore, bermit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service	Licensee			$\frac{1}{2}$	Name and	d Addr dea	ess of u M	Facility Ortu	ary	Servi	ce,	, p.a. MD 2		
	Physician	-	23a. Part I. Enter the disease, or	complications that c		MO150)8 [/	Pari the mode	of dyin	ven	tue,	Gail liac or r	espiratory a	urg rrest, s	hock, or hear	108 /	Approximate Interval
	/Medical		failure. List only one cause on each line.													Between Onset and Death	
	Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):														
		Ļ	Sequentially list conditions, b. Due to (or on a consequence of):														
		amine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Classical India														
	id sit	Exan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	conse	equence o	ıf):										1
	xecuted n and - transit	<u>_</u>	d.														
	so, te be e ysicia	ledi	☑ UNPENDED IF FEMALE:				f,per N	E G9	04	6/1	14/10	TT		12	3d. Date of de	alivan	L
	Box 68760, e death certificate be the attending physic ed for use as the bur	N/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, on the last of th		ne or preg		etal death	. ;	з 🗌	Ectopic p	egnand	у	1	Month	-	ay Year
	ath cer attendi	Physician/Medic	1 Yes 2 No 9 Unknown														
	b. Be the de ched f	Phy	Part II. Other significant condit	a Olikiic		but not re	esulting in the	underlying	a caus	e aive	en in Part I		23e. Did	tobacc	o use contribu	ute to 1	he cause of death?
	, P.O. Box 68760, ires that the death certificate be ex signed by the attending physician be detached for use as the burial.	á	1 Yes										es 2	2 No 3 Probably 4 Unknown			
	ords, w require s been si	eted	24a. Was an 24b												24b. We	ere au	opsy findings available
	e law e has l	Completed	autopsy performed? 1 ✓ Yes 2 No												de	prior to completion of cause of death? 1 Yes 2 No	
	Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the fine of the funeral director, page 2 should the fine funeral director.		25. Was case referred to medica						26.Pla	ace of	Death (C)	neck on	the result	2	100	7 16	s 2 No
	Vita ysicia his cel	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	npatie	nt 2	ER/Outpatier		DOA		205			Resid	lence 6 🗸	Other	Scene
	of ing Ph	L L	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred											ı	-		
	ttendi death.	Certification:	1 Natural 5 Pend 2 Accident Inves	stigation Fd 5	/24	/10	Fd 7:3		1		2 X N	u	nk				
	ivis lor A after din b	ţįį	3 Suicide 6 X Coul	a not be	-		ome, farm, stre	et, factory	y, office	e build	ding, etc.		or Town,	State)	4241 K	ing	at Route Number, City S. Crossing
	Ospital hours a nneral l		4 Homicide	(5,500))		House				4-1-			lvd, i	£312	2 Boy	ıs,	MD
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—trans	Medical	(Check only Certifying Pi	nysician: To the bes miner:On the basis o	f exan												
	ZEND		29b. Signature and title of certifie	and manner st	ated.				c. Lice								th, Day, Year)
1	Ziem Jawette withall, mi) O.C.M.E.								Ma	y 25, 201	0						
		ł	30. Name and address of person	who completed caus	e of de	eath (Item			_				-				
			Pamela E. Southall, M				177		Stre	et, E	Baltimor	e, MC	21201				
	St Regist	6.60	31. Date filed (Month, Day Year)	010 Pener		's Signatu	a de la constante										

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